

Securing Afghanistan's Future: Accomplishments and the Strategic Path Forward

Health and Nutrition Technical Annex



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GLOSSARY OF TERMS

ADB	Asian Development Bank
AFP	Acute Flaccid Paralysis
AIDS	Acquired Immunodeficiency Syndrome
ANHRA (NHRA)	Afghanistan National Health Resources Assessment
AREU	Afghan Research and Evaluation Unit
BHC	Basic Health Centre
BFHI	Baby Friendly Hospital Initiative
BPHS	Basic Package of Health Services
CBHC	Community Based Health Care System
CHC	Comprehensive Health Centre
CHW	Community Health Worker
CDC	Centre of Disease Control
CMH	Commission on Macroeconomics and Health
CSO	Central Statistics Office
CGHN	Consultative Group for Health and Nutrition
CGH WG	Consultative Group for Health Working Group
DDM	National Department of Disaster Management
DOTS	Directly Observed Tuberculosis Treatment
DPT	Diphtheria-Poliomyelitis-Tetanus vaccine
EC	European Commission
ECOSOC	Economic and Social Council
EMRO	Eastern Mediterranean Regional Office (WHO)
EPI	Expanded Programme on Immunization
EPR	Emergency Preparedness and Response
FTE	Full Time Employee
GCMU	Grant and Contract Management Unit
GDP	Gross Domestic Product
HIV	Human Immunodeficiency Virus
ICRC	International Committee of the Red Cross
IDA	International Dispensary Association (Amsterdam)
IDA	International Development Association
IDP	Internally Displaced Person
HIS	Institute of Health Sciences (formerly IMEI)
ITN	Insecticide Treated Bed Net
MAAH	Ministry of Agriculture and Animal Husbandry
MCH	Mother and Child Health
MD	Medical Doctor
MDD	Micro nutrition Deficiency Disease
MDG	Millennium Development Goal
MoF	Ministry of Finance
MoH	Ministry of Health
MMR	Maternal Mortality Ratio
MMRD	Ministry of Rural Rehabilitation and Development
MICS	Multi Indicator Cluster Survey
NIDs	National Immunization Days
NSP	National Solidarity Programme
OECD	Organization for Economic Co-operation and Development

PCC	Provincial Coordination Committee
PHO	Provincial Health Office
PHLO	Provincial Health Liaison Office
PRR	Priority Reform and Restructuring
SFU	Supplementary Feeding Unit
SIA	Special Immunization Activities
STH	Soil Transmitted Helminthes
STI	Sexually Transmitted Infection
TA	Technical Assistance
TB	Tuberculosis
TBA	Traditional Birth Attendant
TFU	Therapeutic Feeding Unit
TISA	Transitional Islamic State of Afghanistan
TT	Tetanus Toxoid
U5MR	Under Five Mortality Rate
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNFPA	United Nations Fund for Population Activities
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Treatment
WB	World Bank
WCBA	Women of Child Bearing Age
WFP	United Nations World Food Programme
WHO	World Health Organization

1 Executive Summary¹

A. Current Status & Accomplishments

1. **Historical Background:** Afghanistan suffered from very high mortality and morbidity even before the Soviet invasion of 1979. The under-five mortality rate in 1960, estimated at 360 per 1,000 live births, was 30% higher than the average of the least developed countries at the time. Twenty three years of war meant that little progress was made in improving health service delivery and the coming of the Taliban worsened an already difficult health situation. Girls and women had very limited access to services since most women health workers were not allowed to work. From 1990 to 2002 the under-five mortality rate hardly changed and Afghanistan is today where most developing countries were 40 years ago.

2. **Current Health Status:** While on-going efforts are contributing to some progress in improving health status, the overall situation remains grim. The under-five mortality rate is now 257 and the infant mortality rate is 165, the highest in Asia and very high compared to other developing countries. The maternal mortality ratio, estimated at 1,600 per 100,000 live births is also very high and reflects the low status of women, poor infrastructure, and a barely functioning curative health care system. The rate of chronic malnutrition (moderate and severe stunting) remains around 50% reflecting a combination of poor caring practices, micronutrient deficiency, and chronic food insecurity. Most of the burden of disease results from infectious causes, particularly among children where diarrhoea, acute respiratory infections, and vaccine preventable illnesses likely account for 60% of deaths. Among adults, tuberculosis accounts for an estimated 15,000 deaths per year with 70% of detected cases being among women.

3. **Current Health Service Delivery:** Most of the Afghan population does not have access to the basic services that could make a large difference to their health. For example, routine immunization coverage (DPT3) is estimated to be only 30% and even this may overstate the reality. Forty percent of existing health facilities do not have female staff, which means that women are very unlikely to access those facilities. More than 80% of what services do exist is provided by Non Governmental Organizations (NGOs).

4. **Accomplishments:** Through successful mass vaccination, the Ministry of Health and its partners have been able to reduce the number of confirmed polio cases in 2003 to 7 in the whole country, a remarkable improvement from the situation in 1997 in which polio caused more disability than land mine injuries. A measles mortality reduction campaign reached more than 90% of children 6 months to 12 years of age resulting in the saving of an estimated 30,000 lives. In addition to leading these activities, the Ministry of Health has taken on a stewardship role in the sector and has developed and communicated a coherent Interim Health Strategy (2002 – 2004), helping to ensure that disparate partners focus on national strategic priorities such as delivering basic health services to the majority of Afghans who live in rural areas, rather than building high visibility, but low impact, tertiary care hospitals.

B. Key Issues and Constraints (Including Cross-Cutting Issues)

¹ All advisors in the Ministry including Dr. Sherzai (MoH), Dr. Feroz (MoH), Dr. Stanekzai (MoH), Gyuri Fritsche (MSC - Consultant), Heike Bill (EC), Paul Fishstein (MSH), Dr. Ahmad Jan, Dr Chris Hirabayashi (UNICEF), Peter Salama (UNICEF), Dr. Majeed (UNICEF), Kayhan Natiq (World Bank), Ben Loevinsohn (World Bank), William Newbrander (MSH), Mike Taylor (OPML), and Omar Noman (UNDP) – others too numerous to mention.

5. **Key Health Sector Issues:** Within the sector, the most important constraint to improving health status is lack of access to basic health services in much of the country. Even simple and effective interventions, such as routine immunization, are only slowly becoming available. The major constraints to improving service delivery are: (i) inadequate number female health staff in rural areas; (ii) shortage of skilled health staff in rural areas generally; (iii) lack of managerial capacity particularly at provincial level; and (iv) managerial and organizational structures that do not provide incentives or accountability for results.

6. **Cross-Cutting Issues:** There are many important cross-cutting issues that impede improvements in health status including: (i) lack of physical security and respect of human rights; (ii) low status of women; (iii) lack of physical infrastructure including rural roads, electricity, improved water supplies, and sanitation systems; (iv) low levels of education, particularly female education; and (v) narcotics and their pervasive effect on health.

C. Strategic Vision, Goals, and Key Priorities

Deliver Basic Package of Health Services (BPHS) to All Afghans: The Government has committed itself to ensuring that the BPHS (a package of services covering maternal and newborn health, child health and immunization, public nutrition, and communicable disease control) is delivered to all Afghans, regardless of where they live, their ethnicity, or gender, in the next 3-7 years. The approach has been the key priority in the sector, is agreed to by almost all stakeholders, and continues to be compelling. The Government will continue to pursue this overarching goal as its first priority, as a means to provide a peace dividend to Afghans, and achieve the Millennium Development Goals (MDGs).

The following two MDGs will be aimed at: Target 5; reduce by two thirds, between 1990 and 2015, the under-five mortality rate and target 6; reduce by three quarters, between 1990 and 2015, the maternal mortality ratio.

While implicit in ensuring the delivery of the BPHS, the Government is committed to reducing inequity in the availability and utilization of health services and will continue to track this by gender, locale, and socio-economic status. Once the current content of the BPHS has been successfully delivered to all Afghans, the Government intends to broaden the scope of the BPHS to include additional services such as mental health, community care for the disabled, and prevention of HIV/AIDS. This will likely be implemented in 7 years but could begin earlier if rapid progress on BPHS delivery is achieved.

7. **Special Programs:** Ensuring the nation-wide delivery of the BPHS will take at least 3 years, and in the mean time the Government will continue to strengthen the vertical programmes and campaigns that ensure blanket coverage of simple but effective interventions such as salt iodination, polio, measles, and tetanus immunization, and vitamin A distribution.

8. **Human Resource Development:** The Government will ensure that every health facility in the country has sufficient female staff and that all staff is properly trained and independently certified to have the skills and knowledge required to deliver high quality health services.

9. **Improve Quality of Hospital Services while Maintaining Centrality of BPHS:** Without compromising the delivery of the BPHS, the Government intends in 3 to 7 years to considerably strengthen the quality of hospital services with priority being given to services such as emergency obstetrical care and trauma management.

10. **Administrative Reform & Capacity Building:** The Government is committed to rigorously testing and evaluating managerial and organizational reforms to improve health service delivery. These reforms will address issues of accountability and incentives for results. Driven by what works rather than ideology, the Government will find productive means to work with the private and NGO sectors. The capacity of Afghans to manage health services will be substantially strengthened with the aim, in 7 years and certainly by 2015, of replacing all expatriates with properly trained Afghans.

D. Costing of the Health Program

Sub-program	Indicators	Est'd Funding requirements to 2006 (M 2003 US\$)	Est'd Funding Gap to 2006 (M 2003 US\$)	Est'd Funding requirements to 2015 (M 2003 US\$)
1. Delivery of BPHS ²	1. Percentage of population covered by BPHS	323.01	178.83	1,519.96
2. Special Programs	a. <u>EPI</u>	<u>Total</u>	<u>Total</u>	<u>Total</u>
	a.1 Number of Polio cases in Afghanistan	40.57	40.57	157.92
a. EPI	a.2 Number of neonatal tetanus cases per 1,000	<u>EPI</u>	<u>EPI</u>	<u>EPI</u>
b. Malaria/Leishm.	a.3 Number of deliveries conducted by trained birth attendants	22.97	22.97	66.17
c. Public Nutrition	a.5 Number of sentinel sites report that report measles cases			
d. Tuberculosis	a.6 Active surveillance of measles cases in all the fixed facilities			
e. Emergency preparedness and response	a.7 Number of fully immunized children with all antigens			
f. HIV/AIDS	b. <u>Malaria/Leishmaniasis</u>	<u>Malaria</u>	<u>Malaria</u>	<u>Malaria</u>
	b.1 % of the of health facilities reporting no disruption of stock of anti-malarial drugs for more than one week during the previous three months	3.2	3.2	13.93
	b.2 % of health facilities able to confirm malaria diagnosis according to the national policy			

² Including the construction program for CHCs, BHCs and first level referral Hospitals

Sub-program	Indicators	Est'd Funding requirements to 2006 (M 2003 US\$)	Est'd Funding Gap to 2006 (M 2003 US\$)	Est'd Funding requirements to 2015 (M 2003 US\$)
	b.3 % of patients with uncomplicated malaria getting correct treatment at health facility and community levels according to national guidelines within 24 hrs of onset of symptoms in target areas			
	<u>c. Public Nutrition</u>	<u>Pub. Nutrition</u>	<u>P. Nutrition</u>	<u>Pub. Nutrition</u>
	c.1 Number of Salt Iodizing Factories	2.13	2.13	12.41
	c.2 Access to iodized salt			
	c.3 Number of millers fortifying wheat according to required quality			
	c.4 Consumption of fortified wheat or other products			
	c.5 Number of TFU training centres (provincial level) within MoH using protocols			
	c.6 Number of district level training centres (operated by BPHS) using protocols			
	c. 7 Number of Hospitals adhering to BFHI standards			
	c.8 Coverage of target population by Vitamin A, iron/folic and zinc supplements distributed through campaigns	<u>TB</u> 3.92	<u>TB</u> 3.92	<u>TB</u> 20.24
	<u>d. Tuberculosis</u>	<u>EPR</u>	<u>EPR</u>	<u>EPR</u>
	d.1 Availability of DOTS throughout the country	2.12	2.12	7.99
	d.2 Quality of DOTS provision			
	<u>e. Emergency preparedness and</u>			

Sub-program	Indicators	Est'd Funding requirements to 2006 (M 2003 US\$)	Est'd Funding Gap to 2006 (M 2003 US\$)	Est'd Funding requirements to 2015 (M 2003 US\$)
	<p><u>response</u></p> <p>e.1 Strengthening of emergency preparedness, mitigation and response activities: Number of trained people, developed/adapted guidelines and standards</p> <p>e.2 Information dissemination and public awareness enhancement on Disaster Management (natural and man-caused disasters and epidemic prone diseases)</p> <p><u>f. HIV/AIDS</u></p> <p>f.1 To expand the knowledge base in order to facilitate planning, implementation and evaluation of STI/HIV/AIDS programmes</p> <p>f.2 Establish safe blood transfusion services in all national and provincial hospitals</p> <p>f.3 Establish anonymous VCT (voluntary counselling and testing) centres</p> <p>f.4 Establish STI/HIV control, care, and support service systems</p>	<p><u>HIV/AIDS</u></p> <p>6.23</p>	<p><u>HIV/AIDS</u></p> <p>6.23</p>	<p><u>HIV/AIDS</u></p> <p>37.18</p>
3. Improve Quality of Hospital Services	<p>1. Case Fatality Rate for Obstetric Procedures</p> <p>2. Bed per 1,000 population in Provinces</p> <p>3. Bed per 1,000 population in Kabul</p> <p>4. Medical Doctor to Bed ratio in Kabul</p> <p>5. Medical Doctor to Paramedical staff ratio in Kabul</p>	82.53	82.53	279.87

Sub-program	Indicators	Est'd Funding requirements to 2006 (M 2003 US\$)	Est'd Funding Gap to 2006 (M 2003 US\$)	Est'd Funding requirements to 2015 (M 2003 US\$)
4. Human Resource Development	<u>a. IHS</u> a.1 Percentage of BHCs staffed with midwives a.2 Percentage of CHCs staffed with midwives <u>b. Continuous Education</u> b.1 Number of trainees that enrolled in continuous education	39.02	39.02	154.06
5. Administrative Reform & Capacity Building	<u>a. Administrative Reform</u> a.1 Number of MoH employees employed in Kabul a.2 Number of MoH employees employed in the Central MoH a.3 Number of MoH employees employed in Public Administration a.4 Number of MoH employees employed in Kabul Hospitals a.5 Number of MoH employees on the payroll a.6 Percentage of allocated budget expended at the Provincial Health Offices <u>b. Capacity Building</u> b.1 Number of TA made available versus requested b.2 The average length of contract for a TA	<u>Admin Reform</u> ³ 12.11 <u>MoH recurrent budget</u> ⁴ 22.90 <u>TA</u> 55.67	<u>Admin Reform</u> 9.98 <u>MoH rec. budget</u> 22.90 <u>TA</u> 55.67	<u>Admin Reform</u> 54.37 <u>MoH rec. budget</u> 52.55 <u>TA</u> 152.37
TOTAL		575.81	429.50	2,371.10

³ This item consists of Central and Provincial MoH administrative staff that is enrolled in the Priority Reform and Restructuring process.

⁴ MoH staff will be employed in the Secondary and Tertiary Hospitals and the Intermediate Medical Institutions. In addition, MoH staff will be employed by NGOs implementing the BPHS. However, as the overall majority of MoH staff (11,000 out of 18,000-ish) is stationed in Kabul, there will be MoH staff on the payroll that cannot be redistributed to other MoH positions in Afghanistan. This 'MoH recurrent budget' therefore starts with all MoH staff on the payroll on their current salary levels in 2003/1382, and a decrease is applied to these numbers over the 12-year period. (Year 1/1393: 100%; year 2/1384: 75%; year 3/1385: 50%; years 4-7: 50%; years 8-12: 25%).

E. Implementation Strategy, Institutional, and Financial Arrangements

11. **Role of Government:** In order to achieve the goals listed above the Government has decided to keep for itself the following roles: (i) financing; (ii) monitoring and evaluation; (iii) coordination of donor inputs; (iv) strategic planning; (v) setting technical standards; (vi) regulation of the for-profit private sector; and (vii) coordination and regulation of the NGO sector.
12. **Delivery of Public Health Services:** The government has not yet decided on whether it wants to take on responsibility for delivering public health services itself or contract with NGOs to do. The decision on this will be made based on rigorous evaluation of current contracts, grants, and Ministry of Health (MOH) strengthening mechanism.
13. **Accountability, Monitoring and Evaluation:** The MOH intends to hold itself and its partners accountable for achieving the goals and targets it has established. This will be done through appropriate household and health facility surveys carried out with 3rd party assistance.
14. **Financial Flows Through Government:** The Government is working towards having most external funding for public health services flow through the Government budgeting system (pooled funding), and expects to make considerable progress on this in the next 3-7 years.
15. **Structure of MOH and Staffing:** With the exception of females, the MOH will not recruit additional health care providers over the next three years and expects to have many of its staff working with NGOs. The MOH will expend considerable effort to strengthen the Provincial Health Offices using the Government's Priority Reform and Restructuring (PRR) process.

2 Current Status and Accomplishments

A. Historical Background

For a better understanding of the current situation of the health sector in Afghanistan a brief summary of the previous twenty-five years shall be given here.

- Before 1978

Even before the political change in 1978, Afghanistan suffered from very high mortality and morbidity, particularly among children and women. Throughout the 1960s, Afghanistan's health system was extremely limited, predominantly hospital and doctor based, and concentrated in urban areas where less than 20% of the population lived.⁵ Even when medical services were available, needs were only partially met, as medical capacities and treatment were far from being adequate and public health care comprised only very basic services in badly equipped facilities lacking adequate hygienic conditions. The 1960 estimated under five mortality rate (U5MR) of 360 per 1,000 live births was 30% higher than the average of the least developed countries at that time, and 61% higher than the average for developing countries as a whole.

Where they could afford it, people preferred to go abroad for difficult operations or medical treatments. For the majority, however, health facilities and services were not yet accessible. Roads and transportation other than donkeys, horses, and camels hardly existed below the provincial or district level. Health care for rural areas was largely restricted to a number of vertically run disease control programmes such as tuberculosis and leprosy, while basic and emergency health services were not available or were very rudimentary. Traditional methods of healing and religiously motivated rituals, often performed by a *mullah* or *hakim*, were in place and until today many people are using them either in conjunction with or instead of Western medicine.

During this time the Government began establishing basic health centres (BHCs), which were intended to be the core of rural public health services. However, due to understaffing and a limited stock of drugs and supplies, BHCs typically saw only 10 to 20 patients a day, despite the intended BHC catchment population of 25,000. Not surprisingly, during the 1970s the infant mortality rate remained at 157 per 1,000 live births, and nearly 60% of deaths occurred before age 5, with malaria, diarrhoea and respiratory infections being the primary causes of death.

Virtually all health services were provided by the Government, with the exception of some private clinics in the large cities run by doctors who in general were employed civil servants and utilized their official working time from their Government jobs. Other health service providers such as international or national NGOs did not exist.

Like the Afghan state administration in general, health administration was highly centralized. At the provincial and district levels, the management structures replicated those of the MoH in Kabul. Typically, civil servants were appointed to work in places other than their own areas with the purpose of ensuring their loyalty towards the central government. Regular quarterly, monthly and even weekly reports were intended to maintain close relations with Kabul. Many officials had very little understanding of local needs and requirements, in part because they often lacked interest in and commitment to their assigned areas. Traditional healing providers and practices were not included in the formal system. It is thus not very surprising that any "modern", i.e.

⁵ Feroz, F., Loevinsohn, B., Newbrander, W. et al, "Letter from Kabul: Formulating Health Policy in Post-Taliban Afghanistan".

Western health approach promoted by the centre did not essentially affect the population and in consequence, proved not to be sustainable.

- Soviet occupation and Mujahedin (1979 – 1996)

During the Soviet occupation and the subsequent civil war, most of the country became totally disconnected from the centre and the major cities. Although the central government maintained its power to appoint governors and managed to protect its interests in the provincial capitals, the district and village levels were, for the most part, subject to the authority of local Mujahedin commanders, in effect decentralizing governance. Management and supervision linkages weakened to the point where they almost ceased to exist, and in consequence, the traditional central planning as well as resource allocation gradually became even more dysfunctional. In the centre and major cities, while relatively better-educated and trained medical staff provided basic medical services, hygiene and health conditions and health-related behaviour hardly changed. During the mid-1980s, international NGOs, many of them Pakistan-based, became significant players in basic service provision to the Afghan population, both for those remaining in the country as well as for those living as refugees in Iran, Pakistan, and Tajikistan. NGOs with experience in conflict situations were funded by the UN and bilateral donors at first to provide services mainly to persons injured in fighting the Soviet occupation, then later to include now underserved rural areas, which could not be supported by the Kabul government. After the signing of the 1988 Geneva Accords, the international community emphasized the development of Afghan NGOs, and provided them with significant funding and support, thereby expanding their role in service delivery. Most of the above activities reflected the various political and humanitarian mandates of the involved organizations and their donors, and thus did not result in standardized health services delivered in a co-ordinated manner. This naturally reinforced the *de-facto* decentralization that outlasted even the hyper centralized Taliban rule and will be difficult for the newly established government to reduce.

In the 1990s, after the withdrawal of the Soviet army and the sharp reduction in international support after the installation of the Mujahedin government, the public health services delivery continued to collapse. In the absence of a centralized controlling administration, the involved NGOs and UN organizations continued to implement emergency and other service programmes with the approval of the relevant local Mujahedin commander or directly with local communities. This continued during the on-going fighting between the different Mujahedin political factions.

- Taliban (1996 – 2001)

While managing to consolidate most of the country politically, the Taliban had neither the capacities nor the interest in policy development and management, especially in the social sectors. Religious leaders replaced health professionals in managing the health sector, and health services, including the construction of facilities, were left in the hands of international and increasingly national NGOs. As a result, neither services nor approaches were very much consolidated or strategic, and health care was only arbitrarily provided. A major impact of the Taliban on the status of the present health providers was the general restriction from education for girls and women and from employment for women (with the exception of the health sector). Strictly imposed gender-segregation also made access to medical care very difficult, especially for women and adolescent girls. The legacy of this restriction remains today.

B. Current Health Status

While on-going efforts by the Transitional Islamic State of Afghanistan (TISA) are achieving some progress in improving health status, the overall situation remains acute. The U5MR is now 257 and the infant mortality rate is 165, the highest in Asia and very high compared to other

developing countries. Major causes of death among children (accounting for 60% of deaths) include diarrhoea, acute respiratory tract infection, and vaccine preventable illnesses. The major source for diarrhoea is the extremely limited access to safe drinking water, estimated as only 13% of households. Additionally, only 12% of households have adequate sanitation. Measles is estimated to cause 10 to 15% of deaths among children under 5.⁶ The extremely high maternal mortality rate of 1,600 per 100,000 live births reflects the low status of women, poor infrastructure, and a barely functioning curative health care system. The major causes of maternal death are hemorrhage, obstructed labour, pregnancy-induced hypertension, and sepsis.⁷ Less than 10% of women have access to prenatal care or are attended by a skilled birth attendant at delivery. The rate of chronic malnutrition (moderate and severe stunting) remains around 50% reflecting a combination of poor caring practices, micronutrient deficiency, and chronic food insecurity. Among adults, tuberculosis (TB) accounts for an estimated 15,000 deaths per year with a very unusual 70% of detected cases being among women.

C. Current Health Services Delivery⁸

The MoH and its partners are primarily committed to implement the Basic Package of Health Services (BPHS) as one of the priorities of the National Health Strategy. According to the Afghanistan National Health Resources Assessment (ANHRA):

- 70% of existing primary care clinics are unable to provide even basic mother and child services
- 90% of hospitals do not have the complete equipment to perform C-sections
- 40% of all basic health facilities do not have female staff
- More than 25% of children die before their fifth birthday
- 40% of child deaths are due to preventable causes of diarrhoea and acute respiratory infections

At present, external financial resources are available to fund the implementation of the BPHS for roughly 40% of Afghanistan's population. (This leaves aside the challenges of very difficult geographical conditions and limited human resources and institutional capacities.) In part due to limited human and technical resources, priority is being given to the first tier of the BPHS, as second tier services in mental health and in disabilities require a relatively high degree of specialization and make a relatively small contribution to reducing mortality.

Availability of Health Services

While the MoH and its partners are stressing the need for facilities to provide the entire range BPHS, at present only a minority are capable of doing so. The following information, taken mostly from the ANHRA, highlights the availability of services under several of the BPHS components.

i Maternal and Newborn Health

While 80% of facilities reported providing some kind of antenatal care, only 28% reported having a female health worker. This reflects in part the difficulty of recruiting qualified female staff, one

⁶ Estimation based on the assessment results of the MoH/UNICEF measles mortality reduction campaign.

⁷ CDC, UNICEF, MoH (2002), *Maternal Mortality in Afghanistan: Magnitude, Causes, Risk Factors and Preventability*.

⁸ Information based on AREU, *The Public Health System in Afghanistan*, 2002. Afghanistan National Health Resources Assessment (ANHRA) April 2003 *Report*.

of the main constraints to improved health service delivery to Afghan women and in consequence often children. Only 65% of those facilities provide the basic set of antenatal care services, including TT vaccination, iron supplementation and blood pressure check, while half reported no delivery related services. While hemorrhage during pregnancy or childbirth is the most frequent cause of death in Afghanistan, only 23% of 176 regional/national, provincial and district hospitals reported having a blood bank. Only 28% of the BPHS facilities claim to offer all four activities recommended regarding newborn care, including clean cord care, immediate breastfeeding, immunization and care of newborn infections.

ii Child Health and Immunization

While 69% of the BPHS facilities claim to address childhood diseases and most (66%) maintain to have staff trained in diarrhoea and/or ARI management, only 24% claim to have special hours to see sick children. Only 54% BPHS facilities claim to participate in the National Immunization Days (NIDs), although routine immunization is offered in only 58% of facilities.

iii Public Nutrition

The specified interventions with regard to nutrition are micronutrient supplementation and the treatment of clinical malnutrition. Two thirds of the BPHS facilities claim to diagnose malnutrition but only 44% state to actually treat malnutrition.

iv Mental Health

While mental health problems (e.g., post-traumatic stress, depression) are understood to be highly prevalent in Afghanistan, their extent is very poorly understood. Mental health belongs to the second tier of the BPHS, and at present it is not clear what services will look like. Yet, half of the BPHS facilities state that they engage in mental health activities, most of them in awareness raising and education.⁹ Treatment of mental health problems is mostly limited to medication, whereas therapeutic care is practically unknown. This is partly because mental health is a highly cultural-specific matter, and imported models are not always compatible with Afghan traditions and beliefs. Very recent approaches such as role-play, gestalt therapy, art therapy or ergo therapy have been successfully piloted mainly with children by a small number of NGOs but so far have not well established. Currently, mental health-related activities are being implemented also under the supervision of the Ministry for Martyrs and Disabled.

v Disabilities

While war-related disabilities such as mine injuries have been very important for public awareness, other causes of disability including cerebral palsy and polio outnumber these by as much as four to one.¹⁰ Only 10% of all facilities say they engage in physical rehabilitation activities. Less than 1% claim to have a prosthesis technician and prosthesis making equipment. Women are especially affected, as trained staff is extremely limited, and disabled women face a very difficult future as their chances to get married are extremely low.

Human Resources

The MoH currently employs 26,000 persons (service, managerial, and support), although this number is not firm. Unfortunately, no gender-disaggregated data are available. The ANHRA recorded a total of 11,820 health workers, of whom only 2,955 (25%) are female.¹¹

⁹ ANHRA survey (2003:32)

¹⁰ AREU *The Public Health System in Afghanistan*, 2002.

¹¹ The table is taken from ANHRA survey (2003:36). The figures, however, have some inconsistencies. In the survey, a total of 12,107 health staff is given, 3,004 female and 9,102 male. Here the individual numbers by job and gender were used, not the totals.

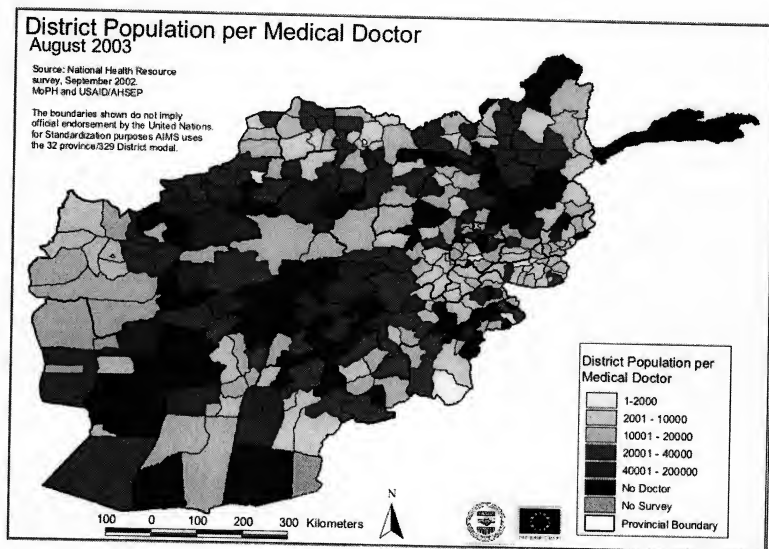
Health staffing by job type and gender			
Job category	Male	Female	Total
Specialist doctors	557	90	647
Doctors	1,598	605	2,203
Doctor's Assistant	1,000	185	1,185
Nurse	2,034	566	2,600
Mid-Wife	22	467	489
Trained Traditional Birth Attendant	0	77	77
Medical Technician	220	38	258
Dentist	130	29	159
Dental Assistant	58	13	71
Optometrist	45	8	53
X-ray Technician	201	12	213
Laboratory Technician	685	62	747
Pharmacist	489	88	577
Pharmacist Assistant	109	18	127
Vaccinator	803	205	1,008
Community Health Worker	859	467	1,326
ENT	35	3	38
Malaria Technician	15	13	28
Physiotherapist	4	3	7
Physiotherapist Assistant	1	6	7
Total Health Staff	8,865	2,955	11,820
Non-health Staff	5,033	1,513	6,546
Total Staff	13,898	4,468	18,366

The table clearly shows that the majority of recorded health staff is medical doctors and specialized doctors (24,3% of the male health staff and 23,5% of the female). About a fifth of the doctors and specialist doctors are women. It further indicates that the more mid-level health professions are not very attractive to women.

According to ANHRA, the number of medical doctors per 1,000 people is 0.1, against 1.1 for all developing countries.¹² This is an average, of course, and there is a great inequality between provinces and districts, as shown in the map below. In provinces such as Balkh there is one

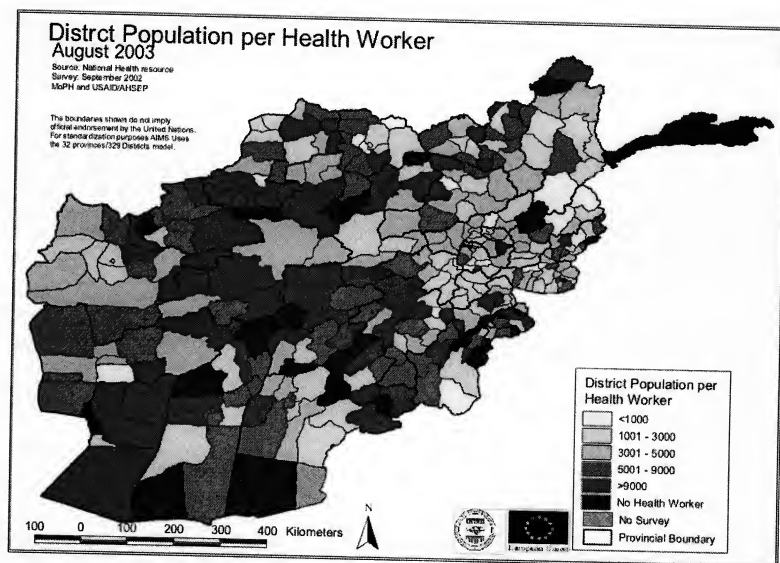
¹² Website The World Bank Group, *Developing Countries – Health, Nutrition – 2001*.

doctor per 1,000 people, while in others such as Oruzgan there is 0.01 per 1,000 people. This situation is particularly unfavourable for female patients, as it is very unlikely that their reproductive health care needs are being met.



The BPHS is tackling this issue in part by including referral structures that begin at the community level, stressing the importance of intermediate-level and community-based health workers (CHWs). Even so, the following map shows that the number of health workers is far less than needed to get acceptable coverage. The ANHRA survey mentions a total number of female and male CHW as well as Traditional Birth Attendants of 9,318.¹³ New policies encourage the adoption of standards for training and support of CHWs, and the integration of CHWs into the health system.

¹³ ANHRA survey (2003:39)



Health Services Providers

At present, the MoH, national and international NGOs, UN organizations, and the private sector all provide health services. While according to ANHRA 43% of all active facilities are owned exclusively by NGOs and 39% exclusively by the MoH, with another 3% mixed MoH/NGO and 10% private ownership, roughly 80% of current services are estimated to be provided by NGOs, mostly under contracts or grants.¹⁴ In the future, NGOs will be mostly supported through some variation of Performance-based Partnership Agreements (PPAs) or performance-based grants. The part of support provided by the MoH is difficult to estimate as some international agencies provide their support indirectly through the MoH or international as well as national NGOs. The majority of MoH owned facilities receive support from the government, NGOs and UN-organizations. Concerning community-based health posts, almost half of them claim to receive support from outside, mainly drugs and supplies as well as training. Here again, the NGOs provide the larger part of support, beside UN-organizations and very limited the MoH. The implementation of the BPHS and other health services delivery depend to a great extent on NGOs, both national and international.

Public Nutrition and linkages to Food Security

¹⁴ ANHRA survey (2003:35)

The nutritional situation in Afghanistan is characterized by an extremely high prevalence of chronic malnutrition, also referred to as stunting which is estimated to be as 45-59%, high mortality rates among children less than five years of age and widespread occurrence of micronutrient deficiency diseases. Despite severe food insecurity, levels of acute malnutrition or wasting remain relatively low, between 6 and 10%. Results from nutrition and health surveys suggest that women, infants less than six months and young children between 6 months and 24 months, are at particular nutritional risk in Afghanistan. The general micronutrient status of the population is poor, largely as a result of the lack of diversity of food in the diet and over-reliance on the staple food commodity wheat. Iodine deficiencies disorders are highly prevalent, particularly in mountainous provinces in the north, north-western and central highlands of the country. The prevalence of clinical cases of goitre, as reported by district-level surveys, is reported to be between 30% - 70% and access to iodized salt was estimated to be <1% during 2001. Localized data for other micronutrient deficiencies show prevalence of 50-70% anaemia among young children and their mothers and up to 20% night blindness among women. In addition, over the past few years outbreaks of scurvy have occurred repeatedly in the winter months with severe clinical signs observed in up to 10% during the winter season. The underlying causes for malnutrition, including food security, an inadequate social and care environment, a poor health environment and lack of access to health care are diverse throughout the country. For example, increasing levels of acute malnutrition or wasting are consistently reported during the hot summer season in urban areas, largely caused by a poor health environment and increase in diarrhoeal disease. (taken from *Public Nutrition Policy*, MOH, November 2003).

Public Nutrition is a key priority in the overall Health Policy of the MOH. The overall goal of the MOH, “*is to reduce malnutrition of all types including micronutrient deficiency diseases through integrated and coordinated programming. In collaboration with partners, the MOH will take leadership in identifying, preventing and reducing malnutrition....*”. (*Public Health Policy*, April 2002 and *Public Nutrition Policy and Strategy*, November 2003). The MOH will promote food and nutrition security for all by adopting a public nutrition approach involving broad-based multi-sectoral interventions that address the underlying causes of malnutrition - including food insecurity, inadequate social and care environment, inadequate access to health services and poor health environment. These policies are strategies are described in detail in the *Public Nutrition Policy and Strategy* (November 2003). Public Nutrition strategies will largely be implemented through the BPHS, described by four important components of assessment, prevention and treatment of malnutrition as well as surveillance. The services delivered through the BPHS is being supported and complemented by central and provincial level interventions such as installation and establishment of eight iodizing salt factories, training centres for treatment of severe malnutrition in provincial-level hospitals and small and large-scale fortification of wheat. Legislation procedures which are underway, including the development of National Code for Marketing of Breast-milk Substitutes and legislation for Salt Iodization will further strengthen the implementation of these nutrition programmes. The BPHS alone is inadequate to address the malnutrition in the country therefore, mechanisms for collaboration and integration on food security including food aid, have been defined with other Ministries, specifically Ministry of Agriculture and Animal Husbandry (MAAH) as well Ministry of Rural Rehabilitation and Development (MRRD).

Water and Sanitation Projects with Health linkage

Only 13% of the population has access to safe drinking water, with the rest taking their water out of rivers, lakes, canals and other sources that provide unsafe water and transmit water-borne diseases. Various national and international NGOs have built wells in order to prevent water borne diseases that can be life threatening for children in particular, and that affect people's

nutritional status. Since September 2003, the MoH in collaboration with UNICEF, WHO and WFP is actively involved in chlorinating wells in Djallalabad and its surrounding villages. The MoH and UNICEF provide the chlorine powder, while WHO are training chlorinators who will receive food (wheat, oil, pulses and iodized salt). In the north, the local Government and communities are involved in providing safe water supported by WHO and WFP by cash and food for work.

D. Accomplishments

In line with its new role as steward of the health sector, the MoH has gained understanding of the major health issues and policy options. It has developed and communicated a coherent Interim Health Strategy for the years 2002-2004, and taken the lead in health policy development, pursuing the priority of rolling out the BPHS, as well as in the coordination of external assistance and thus, has made progress in becoming the main responsible and steward of the health sector.

Governing and Reforming the Health System

The following represent significant achievements of the MoH, with the support of its partners, towards creating a consistent national approach and strategy:

- Specific policies and guidelines have been devised to exert leadership in the sector, including the BPHS (finalized 04/2003 but used for guidance from mid to late 2002), National Salary Policy (08/2003), Recommended Human Resource Development Policy (08/2003), Reproductive Health Strategy (06/2003), and the Package of Minimum Curative Health Services for Hospitals (08/2003).
- A Consultative Group on Health and Nutrition (CGHN), chaired by the MoH, has been established, and functions as a key means of co-ordination between the MoH and major stakeholders (donors, involved UN-organizations, governmental organizations, and NGOs).
- The Grants and Contract Management Unit (GCMU) has been another important new institution in the MoH. The GCMU, established in early 2003, is staffed with national and international technical and medical experts and is responsible for the management and monitoring of contracted out health services delivery.
- Based on the results of the ANHRA, health-planning workshops have been conducted in Kabul and the 32 provinces. As this was the first time that all provincial stakeholders were brought together in a systematic way, the workshops proved to be a major means for disseminating information and policies and in consequence, an institution that will facilitate decentralization processes.
- Co-ordination mechanisms also have been established at the provincial levels of the MoH. Standard Terms of Reference for Provincial Health Coordination Committees (PCC's) have been developed, and are being introduced in all provinces. Under the overall leadership of the Provincial Health Director, each PHCC is responsible for coordinating the activities of all stakeholders in achieving MOH priorities, particularly the expanded delivery of the BPHS, including facilitating synchronization of stakeholder activities to further support quality and accordance with the National Health Strategy.
- A standard salary scale for all institutions providing services has been developed in order to reduce competition on human resources and capacities.

- Other institutional mechanisms such as technical units, working groups and task forces have been established to provide information on status and needs and to recommend on or develop intervention strategies.

Special Programmes

The MoH has successfully implemented several public health programmes in order to meet the immediate needs of the population:

- The Expanded Programme on Immunization (EPI) includes vaccinations against Measles, Polio, Tetanus, DPT and BCG. Approximately 11.5 million children have been vaccinated for measles, attaining national coverage greater than 90%.
- Vitamin A deficiency is wide spread especially among children and has been addressed by particular public campaigns. Vaccinating more than 6 million children and administering vitamin A to more than 5 million achieved coverage greater than 90%.¹⁵
- The MoH, in collaboration with UNICEF and WHO has established an emergency supplementary feeding programme including nutritional therapeutic centres. More than 300,000 malnourished children and women were provided with supplementary and therapeutic feeding.

¹⁵ Health and Nutrition Public Investment Programme

3 Key Issues and Constraints (including cross-cutting issues)

Key Health Sector Issues

The majority of the Afghan population does not have access to a health facility and thus to the basic services that could make a large difference to their health. The reasons for this situation are complex, and include inadequate number of female health staff in rural areas; shortage of skilled health staff in rural areas generally; lack of managerial capacity particularly at provincial level; and, managerial and organizational structures that do not provide incentives or accountability for results. Of the 912 facilities listed as active in ANHRA¹⁶, not all offer all services that are included in the BPHS or are all personnel assigned to the facility working. One third (95 districts) of all districts are currently above the 1 facility to 30,000 population norm proposed by the MoH as a short-term goal. Moreover, the distribution of health facilities is not at all geographically balanced, and there is significant variation in the number of population served by one facility between provinces as well as districts within provinces. In addition, successful implementation of the BPHS requires essential medical and technical equipment and specific supplies, as well as electricity and access to safe drinking water.

i. Inadequate number of female health staff in rural areas

Perhaps the most important health sector issue is the inadequate number of female staff, especially in rural areas. This is the result of a number of social and cultural conditions, described below, which make it difficult to recruit and retain female health workers. The constraints to staffing of health facilities with females in turns make it difficult for women to attend. At present, 40% of existing health facilities has no female staff. In addition to the actual numbers, due to females being deprived of technical training under the Taliban, they may overall have lower capacity than their male counterparts. Due to restrictions placed on employment, many women lost their professional skills and practice and in consequence, often their technical knowledge. Even before the Taliban, many of the well-trained and educated medical doctors left the country beginning in 1978, and continuing with successive regime changes and political turmoil. National and international NGOs have developed training and employment strategies to increase the ratio of female staff especially in rural areas, although the demand is enormous. Without the support of the MoH and other government institutions as well as religious and social leaders however, it is very unlikely that their approaches will be sustainable. One possibility is to take advantage of returnees, who may have had opportunities in Iran or Pakistan for exposure to community-based health care, health education, or training, as potential health care workers or as community resources. Equitable, effective and efficient delivery of the BPHS will need well-trained female health staff of all levels, especially the rural one.

ii. Shortage of skilled health staff in rural areas generally

In general, the clinical skills of providers have been degraded over the years of conflict due to retirement or emigration of skilled instructors, lack of financial and material resources, restricted access to equipment as well as current technical information, and the rapid expansion of medical schools. More recently, the practices of the Taliban regime also affected the quality of male as well as female medical education. In consequence, the skill of faculty graduates in recent years is questionable. Just as important, however, historically, it has been difficult to attract and retain

¹⁶ ANHRA survey (2003:6)

staff at the rural areas, largely because of the amenities (e.g., education for children) and earning opportunities offered in the large cities. Taking the number of doctors in MoH employment, it transpires that while the ratio of physicians to population in Kabul is 1:1,765, the number in the rest of Afghanistan is 1:14,432.

iii. Lack of managerial capacity particularly at provincial level

In addition, there is a lack of management capacity at the provincial level, for a number of reasons. First, there has historically been an emphasis on clinical rather than management. Second, public health is a relatively new discipline for Afghanistan. Third, the role of the MoH has been changed from provider to steward, and the process of making the needed changes in attitudes and expectation will take some time. In addition, the relationship between MoH Kabul and the Provincial Health Offices (PHOs) is yet to be clearly defined. The PHOs (as well as the provincial representatives of other ministries) look to Kabul for decisions. At present, the PHOs are typically not involved in the budget preparation. On the other hand, the required capacities to manage and control their budgets still do not exist. Both as a cause and an outcome of the above factors, the level of budget execution (spending) of the PHOs is low (typically 25% of budget) due to non-availability of cash.

iv. Managerial and organizational structures that do not provide incentives or accountability for results.

The MoH along with other Government ministries and institutions are undergoing reform. At present, without a formal system of reporting and supervision, especially at the provincial level, accountability is limited. Aside from the as of yet unclear understanding of the new role of MoH and the PHOs, a lack of position descriptions with clear responsibilities and with regular objective review discourages high performance. The lack of financial and material resources with which to carry out tasks, including planning and supervision of NGOs and other providers, has similarly discouraged MoH staff. Above all else, however, the low level of Government salaries requires that staff support themselves and their families through other means, often at the expense of time and effort spent at their official jobs. A recently approved Priority Reform and Restructuring procedure for the Provincial Health Department could bring considerable change in this situation. If introduced as envisaged, the MoH employees will be selected through a fair and transparent process based on merit only, and once in position, they will be appraised regularly. The penalty for underperformance will be the loss of the interim additional allowance, which, depending on the position, is a sum between \$150 and \$635 per month.

Cross-Cutting Issues:

In addition to the above issues within the health sector, a number of cross-cutting issues affect both health outcomes and the ability to manage and deliver health services. These issues include lack of physical security and respect of human rights; status of women; lack of physical infrastructure including rural roads, electricity, improved water supplies, and sanitation systems; economic constraints; low levels of education, particularly female education; and, narcotics and their pervasive effect on health.

i) Lack of physical security and respect of human rights

Above all else, Afghans yearn for physical security. As such, physical security is the ultimate crosscutting issue. Without basic security, Afghanistan citizens will be unable to maintain their own health and well-being and service providing institutions will not be able to maintain their own activities. The implementation of the BPHS to all Afghans will only be feasible if the security situation improves and stabilizes. Availability and access to health services is a basic human right, which would be taken for granted for all Afghans. While physical security and human rights do not originate in the health sector, health has been one of the sectors in which community participation encouraged, however sporadically. Involvement, participation, and commitment of the communities through the strategy of community-based health care can contribute to developing a sense of ownership with the regard to the improvement of the health situation, and can even encourage the provision of human rights to all citizens.

ii) Status of women

The status of women is obviously an issue, which affects most sectors, not just health. To achieve a substantial impact on the equity, effectiveness, and efficiency of the health programmes, gender issues need to be addressed at the societal, institutional, and policy level. Afghanistan society, especially in the rural areas, is a conservative, tribal and exclusive society with rather strong social values, norms, and customs, including gender segregation and the division of space into private and public. While these traditions may vary among regions, ethnic groups, and families, in some areas females are discouraged from receiving an education, travelling, or working outside of the home, especially in work that puts them in regular contact with strangers. Existing cultural and religious traditions concerning female public mobility affect access to health care in a number of ways. First, in many areas, it is unacceptable for a woman to consult a male doctor or be taken care of by male health workers. Of course, it is almost equally unacceptable for a female provider to treat a male patient, although given the gender ratio of providers; this poses much less of a constraint. Second, these same traditions drastically reduce the ability to recruit and retain female health workers, which would in turn make it acceptable for women to attend. As noted above, at present, 40% of existing health facilities has no female staff. It is very unlikely that in particular the rural, non-literate population will change their health-related behaviour, even if there were more facilities accessible.

iii) Lack of physical infrastructure including rural roads, electricity, improved water supplies, and sanitation systems

Another factor reducing access to health care is Afghanistan's degraded infrastructure, especially roads. Access is especially difficult during the winter and after heavy rainfall. Rehabilitation and construction works are going on but there is still much work to be done. According to ANHRA, most facilities are within 40 minutes from a paved road¹⁷, but the majority of the Afghan population does not live near a paved road. The required long hours travel by foot, donkey, or camel to reach health facilities is particularly difficult for women who need emergency obstetric care, seriously ill people who need continuous or repeated treatment and for the wounded.¹⁸ As noted above, successful implementation of the BPHS requires electricity and access to safe drinking water. According to ANHRA, only 34% of active health facilities have electricity available, of which only half is city power. Concerning sanitation, public awareness on environment-related issues -- including use of natural resources, energy, and disposal of waste -- is poorly developed in Afghanistan and impacts the health status of the population. Water management in particular is a vital environmental issue, as water borne diseases such as diarrhoea

¹⁷ ANHRA survey (2003:19).

¹⁸ WB/AREU (March 2003:48).

are among the causes for death especially of children under five. This would include not only the provision and maintenance of safe drinking water but also the use of clean and disposal of contaminated water.

iv) Economic constraints

Poor purchasing power is another constraint to access to health services. This takes the form of lack of ability to pay for transportation to a health facility; lack of ability to purchase medicines or even pay for needed health services (formally or informally).

v) Low levels of education, particularly female education

The majority of Afghan women and men living in rural and remote areas are non-literate and do not have any formal education or training. This means that the population generally has a limited understanding of personal behaviours (i.e., drinking water, sanitation) and their affect on health status. They also tend to defer to doctors rather than taking a pro-active role in their own well-being, especially concerning preventive health care. Finally, the low level of education and literacy results in a limited pool of prospective health workers, from CHWs on up. This is especially acute for females and particularly from the time of the Taliban when female education was restricted.

vi) Narcotics and their pervasive effect on health.

Afghanistan is the world's major source of opium, now providing over 70% of the world's supply. This affects the health sector in at least two ways. First, domestic drug addiction is expanding, although it is not yet publicly recognized that Afghanistan has a drug abuse problem. Dangerously, this is certain to increase the incidence of HIV/AIDS and other blood borne viruses' spreads, and treatment and rehabilitation for drug abusers will be among the future health needs of the population. Second, the expansion of the drug economy will undercut progress made in the areas of governance and rule of law, decreasing the ability of public and private institutions to plan, manage, and deliver health services. It will be the task of the various involved line ministries and other institutions to make the obvious connections between drug abuse and livelihood, law enforcement, etc.

4 Strategic Vision, Goals, and Key priorities

Strategic Vision

The objective of the National Health and Nutrition Programme is to reduce the high levels of mortality and morbidity, especially among women and children, through the development of equitable, effective and efficient health services that address the priority health and nutrition problems, and through developing the capacity to deliver the necessary services. (Health and Nutrition Public Investment Programme; National Development Budget, February 2003)

A. Delivery of the Basic Package of Health Services (BPHS)

To facilitate its objectives the Ministry of Health (MoH) in March 2003 finalized the BPHS, a standardized package of basic services which forms the core of service delivery in all primary health care facilities and consists of the following components:

- (First tier)
 - Maternal and Newborn Health
 - Child Health and Immunization
 - Public Nutrition
 - Communicable Diseases
 - Supply of Essential Drugs
- (Second tier)
 - Mental Health
 - Disability

The BPHS includes comprehensive and basic emergency obstetric care at provincial and district levels respectively, curative and preventive care at health facilities and enhanced community health activities. High priority is given on maternal and child health and a special focus on safe motherhood in order to tackle the devastating maternal, infant and child mortality rates. The BPHS shall be available to all Afghans, regardless of their ethnicity or gender, even to those living in remote and underserved or un-served areas in the next three to seven years. It also specifies different facility types, staffing pattern for the facility types, equipment and supplies, etc. and thus, beside the substance, also provides the system for implementation.

B. Reduction of communicable diseases

Alongside, immunization services are made available and accessible to all children and women on equitable basis to increase and sustain high immunization coverage and to reduce morbidity and mortality due to vaccine preventable diseases. These interventions include BDG, Measles, DPT, Polio, Tetanus and vitamin A. Other special programmes such as for the defeat of Malaria, Leishmaniasis or Tuberculosis are corresponding with the objective to decrease incidence of communicable diseases.

C. Establishment of prerequisites for the implementation of the BPHS

Additionally, enhanced national capacity at all levels of the MoH to manage and implement basic health services will be significantly strengthened within the set five to seven years. The necessary infrastructure will be established and all health facilities staffed in line with the BPHS. The required human resources female in particular, will be recruited and adequately trained to deliver high quality basic health services so underserved or un-served areas will no longer be existent. Health services delivery will mainly be provided by national and international NGOs.

D. Goals and key priorities

The goal of this programme is to work towards Health for All based on a primary health care approach, underscored by the principles of fairness and equity in resource allocation and service provision, good governance, a decentralized and integrated health system, community involvement, and strong inter-sectoral collaboration and co-operation. (Health and Nutrition Public Investment Programme; National Development Budget, February 2003)

Based on the priorities and objectives of the Interim Health Strategy and the Health and Nutrition Public Investment Programme for 1382, the following five sub-programmes have been proposed for the next five to seven years. The sub-programme objectives are presented in general terms, with the targets provided in section 5 (“outcome/service delivery indicators and targets”) and a fuller explanation given in section 8 (“development programme and budget”).

i Expansion of the scope of the BPHS, i.e. delivery of both tiers of the BPHS to all Afghans

The Government has committed itself to ensuring that the BPHS (a package of services covering maternal and newborn health, child health and immunization, public nutrition, and communicable disease control) is delivered to all Afghans, regardless of where they live, their ethnicity, or gender, in the next 3-7 years. The delivery of the BPHS is planned through four levels of facility (health post, basic health centre, comprehensive health centre, and district hospital), each with its own staffing pattern and defined catchment area. In addition, Community Health Workers (CHWs), trained and supported from a health facility, will be key agents in delivering preventive and basic curative health services to remote areas. The BPHS was designed with an eye to making the most cost effective use of scarce resources; the estimated annual per capita cost is \$4.55 (USD 2001). The BPHS approach has been the key priority in the sector, is agreed to by almost all stakeholders, and continues to be compelling. The Government will continue to pursue this over-arching goal as its first priority, as a means to provide a peace dividend to Afghans, and achieve the Millennium Development Goals (MDGs).

According to MoH strategy, NGOs will be the main implementers for the BPHS, while the MoH at central and provincial levels will be responsible for planning, coordinating, regulating, monitoring, and supervising NGOs and the private sector.

While implicit in ensuring the delivery of the BPHS to all Afghans, the Government is committed to reducing inequality in the availability and utilization of health services and will continue to track this by gender, locale, and socio-economic status. Once the current content of the BPHS Tier 1 has been successfully delivered to all Afghans, the Government intends to broaden the scope of the BPHS to include additional Tier 2 services such as mental health, community care for the disabled, and prevention of HIV/AIDS. This will likely be implemented in seven years but could begin earlier if rapid progress on BPHS delivery is achieved or if additional policy changes are introduced based on an analysis of the current situation.

Funds currently available will cover only about 40% of the population. For 1383 (2004), only \$42.9 million is available, against an estimated requirement of \$87.38 million. The population coverage targets for providing the BPHS are 80% for year 3; 90% by year 7 and 95% by year 10. (More detail is provided in Annex 3, Detailed Costing Calculations and Tables.)

ii Special programs

While most services will ultimately be integrated into the BPHS, this may require at least three years. In the mean time, the Government will continue to strengthen several critical vertical programmes and campaigns that ensure blanket coverage of simple but effective interventions. These special programmes are: EPI (polio, neo-natal tetanus, measles, routine vaccination coverage); malaria and Leishmaniasis; public nutrition; tuberculosis; emergency preparedness, mitigation, and response; and HIV/AIDS.

iii Maintain and improve the quality of hospital services without jeopardizing the quality of other health services delivery

Without compromising the delivery of the BPHS or returning to the historically skewed allocation of resources to hospitals, the Government intends in 3 to 7 years to considerably strengthen the quality of hospital services with priority being given to services such as emergency obstetrical care and trauma management. Policies are currently being developed by a national Hospital Task Force based on information produced by ANHRA (2002) and a focused national hospital survey conducted in October – November 2003. This will include defining a package of essential hospital services, designing a generic hospital classification, rationalizing of the district (included in the BPHS), provincial, regional, and tertiary hospitals to reduce the current concentration in Kabul and improve access to other areas, and improving quality.

iv Human resource development

The Government will ensure that every health facility in the country has sufficient staff, especially female, and that all staff is properly trained and independently certified to have the skills and knowledge required to deliver high quality health services. A total of 10,000 nurses, midwives and other paramedical staff will need to be newly trained by 2013 to meet the demand of the expanding health service delivery system. In addition, hundreds of medical professionals will need to enrol in continuous education courses to refresh and update their knowledge. To this extent, nine Intermediate Health Sciences (IHS) Institutes will be rehabilitated, and three will be constructed. Twelve IHS's will, hopefully, be operational by 2013.

v Administrative Reform and Capacity Building

The Government is committed to rigorously testing and evaluating managerial and organizational reforms to improve health service delivery. These reforms will address issues of accountability and incentives for results. Driven by what works rather than ideology, the Government will find productive means to work with the private and NGO sectors.

The capacity of Afghans to manage health services will be substantially strengthened with the aim, in 7 years and certainly by 2015, of replacing most expatriates with properly trained Afghans. The Technical Assistance needs will be maximum in years 1-3 (2004-2006) from now. There will be an intermediate need in the years 4-7 (2007-2010) and a lesser need in the years 8-12 (2011-2015).

5 Outcome/Service Delivery Indicators and Targets

The table on the following page presents the indicators for the five sub-programmes mentioned above, along with the baseline and the targets for each of the three periods. Additional explanation on the determination of indicators and targets is given in the subsequent text sections (especially in “development program and budget”) and in Annex 2.

PROGRAM NAME: Health

Solar year	1381	1382	1383	1384	1385	1386	1387	1388	1389	1390	1391	1392	1393	1394
Fiscal year	2002/03	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
#	1	2	3	4	5	6	7	8	9	10	11	12		

Millennium Development Goals

1. Maternal health: Three-quarters reduction in maternal mortality rate.	1,600	1,000	400
2. Child mortality: Two-thirds reduction in under-five mortality rate.	257	150	86
3. HIV/AIDS and malaria: a) By 2015, halt and begin to reverse the spread of HIV/AIDS. b) By 2015, reverse the incidence of malaria and other major diseases.	see annex	see annex	see annex

Target for service delivery

Subprogram 1: Basic Package of Health Services (BPHS)	50%	90%	95%
Indicator 1: % of population covered by BPHS.	see annex	see annex	see annex
Subprogram 2: Special programs	na	< 1%	< 1%
Indicator 1: % of population covered	na	< 1%	< 1%
Subprogram 3: Hospitals	31%	70%	90%
Indicator 1: Case fatality rate for obstetric procedures	36%	75%	95%
Subprogram 4: Human resource development	TBD	TBD	TBD
Indicator 1: % of BHCs staffed with midwives.	65%	75%	90%
Indicator 2: % of CHCs staffed with midwives.	65%	75%	90%
Indicator 3: Ratio of physicians to allied health care workers.	65%	75%	90%
Subprogram 5: Administrative reform & capacity building	40%	75%	90%
Indicator 1: % of allocated budget expended by PHOs	40%	75%	90%

6 Costing of Outcome/Service Delivery Targets

All service delivery targets of all sub-programs are aimed at reaching the two Millennium Development Goals specified in the Development Program and Budget section.

It is important to realize the mutually reinforcing nature of the various sub-programs. For instance: (i) the construction program for Health Clinics is in line with the planned growth of the BPHS service delivery network; (ii) the Special Programs are in line with the size and expected growth of the BPHS service delivery network (for instance the EPI expected number of fixed EPI facilities); (iii) the Special Programs are all built upon the expected size of the BPHS (there will be no use for funding only Special Programs as they will have no service delivery network); (iv) the training capacity of the IHS's is designed with a knowledge on the expected demand for and distribution of essential categories of, mainly female, health staff; (v) the Technical Assistance needs' for all five sub-programs are brought under sub-program five 'Administrative Reform and Capacity Building'.

The five, mutually enforcing and interdependent, sub-programs of the Health and Nutrition Sector are:

1. Basic Package of Health Services
2. Special Programs
3. Human Resource Development
4. Improving the Quality of Hospital Services
5. Administrative Reform and Capacity Building

6.1 Basic Package of Health Services

The Basic Package of Health Services (BPHS) has been costed.¹⁹ The total cost, based on a population of 300,000 Afghans, is estimated at \$4.55 (2001) per capita per year. The cost of the first layer is estimated at \$1.13 per capita per year, the second and third layers are estimated at \$2.41 per capita per year, and the cost of the fourth layer, the Community Based Health Care (CBHC) system, is estimated at \$1.01 per capita per year. The costing of this BPHS, of \$4.55 per capita per year in 2001 US\$, is fairly accurate; the evidence so far, with the costing of Province wide interventions, points at an average cost of about \$3.80 (2003 US\$) per capita per year to deliver this minimum BPHS ratio. For interventions that cover districts, or clusters of districts, this cost does not hold; far higher sums are needed for this type of intervention.

The targets for implementing the minimum ratios of the BPHS are: 80% for year 3; 90% by year 7 and 95% by year 10.

In year 1385 (2006), \$0.25 per capita will be added to pay for community based disability and mental health. This sum is a guesstimate informed by an absolute lack of monies. This small sum would still provide \$4.7 M per year for these second tier components of the BPHS.

¹⁹ Costing of the Basic Package of Health Services for Afghanistan, Management Sciences for Health, March 31, 2003.

6.2 Special Programs

- (a) Expanded Programme on Immunization
- (b) Malaria and Leishmaniasis
- (c) Public Nutrition
- (d) Tuberculosis
- (e) Emergency Preparedness and Response
- (f) HIV/AIDS

All special programs are built upon the Basic Package of health services, where trained and regularly paid staff, adequately equipped facilities and most essential drugs is available.

Below, cost figures and assumptions used to cost the various special programs are given. For more details see annex 3 'Detailed Costing Calculations and Tables'.

(a) Expanded Programme on Immunization

The costs include recurrent costs related to vaccines and syringes and needles and the like, the capital costs include cold chain equipment and accessories. All calculations are based on a certain population size and 3% inflation.

Assumptions related to recurrent cost estimations for EPI.

1. 22.2 M 2003 Population with a 1.92% growth rate.
2. All calculations made are for 100% coverage including National Immunization Days (NIDs) which are different from Vaccine forecasting sheets supplied by Copenhagen (the main supplier).
3. Vaccine wastage factors: Routine EPI (BCG-50%, Measles-50%, DPT-40%, Polio-40%, TT-40%).
4. Vaccine wastage factors: For SIAs (Polio-20%, Measles-20% & TT-20%).
5. TT vaccine calculation done on the basis of Pregnant women. Two doses for every pregnant woman.
6. In reality half of all pregnant WCBA will be eligible for one dose due to their previous TT shots. Remaining doses will be utilized for non-pregnant CBAs.
7. For measles campaigns 17% of the total population has been calculated (9-59 months).
8. For TT SIAs: In 2004 100% of the total CBAs are calculated.

Assumptions related to capital cost estimations for EPI.

1. Cold chain equipment life is five years, hence replacement will take place after 5 years
2. Cold box and vaccine carrier life is 10 years
3. Start with 800 facilities in 2004 and end with 1375 by year 2015; in par with the expected targets in the BPHS
4. A ten percent increase in unit cost is added per year
5. Spare parts for absorption type units to be changed each year
6. Spare parts for compression type units to be changed every other year
7. Initial number of fixed centre=800, provincial cold rooms=23 and regional vaccine stores=7
8. Annual inflation rate 0%

(b) Malaria and Leishmaniasis

The Malaria Program, like the other special programs, is built upon the existing service delivery network. All costs are in constant 2003 US\$; nil adjustments in inflation were made.

Assumptions and costing figures used to cost the Malaria program

Malaria drug	Uncomplicated cases can be managed under the BPHS, but severe and complicated P. Falciparum cases (around 20% of all cases) need Artesunate/Fansidar new regime, which are not included in the essential drug lists. 1.2\$ per patient. Accessibility of this drugs, 25% in 2004, 30% in 2005, 40% in 2006, 50% in 2009, 60% in 2011, 70% in 2013, 80% in 2015 accordingly
Contingency for outbreaks	Procurement of outbreak response contingency stocks for 14 provinces. \$100,000 lump sum
Training for Malaria	For doctors, 5 days training course, at an average cost \$30 per person, for other Health workers, 3 days training course, at an average cost of \$12 per person
Training for BPHS integration	\$1,000 lump sum for the remaining 18 province with 3% inflation
Insecticide Treated Bed nets (ITNs)	ITNs (\$2 per net) distribution policy: free distribution for widows' households, \$1 subsidies for the population in rural areas; in urban areas ITNs will be sold in shops at an average cost of \$2. Average size of one household is seven, i.e. total target households in 14 provinces are around 1.1million, and 3.3% among them are headed by a female (from MICS 2003). ITNs would be replaced once per 4-5 years

(c) Public Nutrition

**Budget estimate for costing of the Public Nutrition over and above the BPHS (all complementing and supporting the implementation of the BPHS at District level)
Public Nutrition Department, December 2003**

	Per year (US\$)	Comments
Universal Salt Iodization		
Monitoring and quality Control	10,000	Testing at production sites
Laboratory capacity and support (urine analysis)	50,000	\$5/test, establishing one lab is \$50,000
Communication, social marketing and advocacy	20,000	TV, media etc
Training, global networks, debates a advocacy	5,000	Travel, and training (access global networks)
Fortification of wheat (central silo, decentralized millers, Super flour)		
Monitoring and quality Control	10,000	Testing production sites
Laboratory capacity and support (blood, urinary analysis)	40,000	For testing levels
Communication, social marketing and advocacy,	20,000	TV and media

legislation		
Training, global networks, debates a advocacy	5,000	Travel, training
Treatment of Severe Malnutrition		
Support for 10 Training Centre TFUs (Provincial Level)	360,000	F100, F75 supplies, staff support, drug equipment for 10 Training Centre TFUs (over and above BPHS) (@3,000 per month per TFU)
Support for 30 TFUs (District level)	360,000	F100, F75 supplies for 30 TFUs at District level @ \$1,000 (additional support to BPHS NGO)
Support for Baby Friendly Hospital Initiative and implementation of National Code		
Training, monitoring	20,000	Monitoring National Code and support for 12 hospitals to adhere to the Baby Friendly Initiative

(d) Tuberculosis

Nil adjustments to inflation were made; all costs are in constant 2003 US\$.

Assumptions and basic planning figures used for costing the TB program

TB drugs	Cost of one treatment regimen: \$14
Training for DOTS	150\$ per microscopist, \$80 per person, \$50 per person, 2 health workers per facility, \$30 Per person, 2 community health worker per facility, \$ 2,500 per province as lump sum, all with 0% annual inflation
DOTS shelter	Simple accommodations for rural TB patients who have problems to go to health facilities, so as to ensure completing DOTS therapy. Basically facilities are donated or contributed by communities. Renovation fee is required (\$20,000 per facilities), at least one shelter per province
DOTS shelter operation costs	Every month \$200 per shelter, one administrator (\$100 per month), two support staff (\$50 per month), with 0% inflation of operation costs and 0% inflation of staff costs
Microscope	\$ 2,500 per province, replace with new one after seven years
Spare parts	\$ 125 (5%) per microscope,

(e) Emergency Preparedness and Response

Nil Adjustments to inflation were made: all costs are in constant 2003 US\$.

Assumptions used for costing the Emergency Preparedness and Response program

Drug medicine	Every 2 months, medium scale outbreaks (diarrhoea, Shigella, hemorrhagic fever etc exclude malaria), target 10,000 to 20,000 population, one operation, \$15,000 operation costs, \$25,000 medicine/vaccine costs
National Reference laboratory	Five medical doctors (\$170 per month), 13 lab technicians (\$120 per month), 20 support staff (\$50 per month)
National Reference laboratory	1,000 referral tests per month, with 5% annual growth. Test cost ; average \$3 per test with 0% inflation, including HIV, Hepatitis, Cholera, Shigella, Dengue fever, Helminthes, Diphtheria, E. Coli
Regional Reference Lab	100 referral tests per month, with 5% annual growth. Test cost ; average \$3 per test with 0% inflation, including HIV, Hepatitis, Cholera, Shigella, Dengue fever, Helminthes, Diphtheria, E. Coli
Regional Reference Lab	In each reference lab, located in the regional hospital, one medical doctor (\$170 per month), 2 lab technicians (\$120 per month), 4 support staff (\$50 per month)

(f) HIV/AIDS

Nil adjustments to inflation were made; all costs are in constant 2003 US\$.

Assumptions used for costing the HIV/AIDS program

National Surveillance System	One sentinel facility \$10,000 lump sum per year, By 2010, a total of 41 sentinel sites will be established (Kabul 5, Heart 3, Nangarhar 2, Balkh 2, and Kandahar 2. For the other provinces (one per province) with 0% inflation. Add \$20,000 of initial capital investment for reference laboratory in Kabul 2, Herat 1, Nangarhar 1 Balkh 1 and Kandahar 1
Equipment with spare parts for safe blood trans fusion	One refrigerator \$800 per new open blood bank with 10% spare parts fee. In every seven years, exchanged with new equipment. Annually the equipment price is increased with 0% inflation
Blood bags	\$1 per bag with 0% annual inflation. Two units per transfusion on average
HIV Rapid test	\$1 per test
HIV ELISA test	Conducted in six confirmation centres. One facility \$3,000 lump sum per year with 0% inflation
HB Antigen kit	\$0.7 per test
HCV kits	\$0.7 per test
Syphilis test	\$.5 per test
Condom social marketing	\$0.2 per one condom, Target distribution number is 1.5% of young age population, and 10 to 15% will be sold in the markets
VCT centre training	\$3,000 lump sum for initial training, \$1,000 lump sum per VCT centre for refresh training
VCT human resource	Five regional VCT have three doctors (\$200 per month), two lab-technicians (\$120 per month), three support staff (\$80), other VZCT facilities have one doctor (\$200), one lab-technician (\$120) and one support staff (\$80), with 0% annual salary inflation.
VCT test kits	1,000 tests monthly for five regional VCT centres, and 30 tests for other VCT centre monthly, 1\$ per tests and \$0.5 IEC material
High risk group	Including IDUs 3,500, Men sex with men 100,000, Commercial sex worker 8,000 and their clients 80,000, drug abusers 200,000 with 2%

	annual growth
BCC interventions	\$30 lump sum per one high risk person to change behaviours (by peer groups and NGOs), Target is 2 to 7.5% (by 2015) population among high risk groups per year.
National Advocacy	\$50,000 lump sum including national consensus meeting, advocacy workshop with 0% inflation
IEC and life saving skill	Integrated in-school training, \$2 per person lump sum; the target is 60% of 14 years old populations
STI treatment	Majority of services are provided by NGOs, \$20,000 lump sum for technical supports and drugs with 0% inflation
HIV/AIDS treatment and care	AIDS ARV Treatment \$40 per month per person, annually 15 patients participate in the regime, plus \$30,000 care lump sum with 0% inflation
HIV/AIDS supports	Create peer support groups with NGOs collaboration in five major cities by 2015. \$50,000 lump sum support for each group

Cost Forecast of Special Health Programs

	2004	2005	2006	2007-2010	2011-2015
EPI					
Recurrent	7,542,043	5,762,092	7,605,556	15,689,924	22,219,184
Capital	1,177,786	385,365	466,136	2,446,847	2,836,135
Total	8,719,829	6,147,457	8,071,692	18,136,771	25,055,319
TB					
Recurrent	885,645	1,122,533	1,223,896	5,993,725	7,848,315
Capital	247,500	245,000	197,500	1,290,709	1,177,127
Total	1,133,145	1,367,533	1,421,396	7,284,434	9,025,443
Malaria					
Recurrent	956,058	1,122,221	1,171,551	4,637,219	6,091,493
Capital*1					
Total	956,058	1,122,221	1,171,551	4,637,219	6,091,493
Public Nutrition					
U Charge	303,621	386,814	394,241	1,654,124	2,252,705
Recurrent	680,000	751,065	655,295	3,221,012	7,061,961
Capital	100,000				
Total	780,000	751,065	655,295	3,221,012	7,061,961
STI/HIV/AIDS					
Recurrent	1,732,928	2,077,251	2,344,750	11,012,779	19,743,715
Capital	28,280	32,320	12,120	48,480	149,480
Total	1,761,208	2,109,571	2,356,870	11,061,259	19,893,195
Emergency Response					
U Charge	12,218	12,453	12,692	57,731	125,843
Recurrent	552,020	559,725	566,417	2,342,315	3,128,728
Capital	423,750	11,250	11,250	177,554	220,019
Total	975,170	570,975	577,667	2,519,870	3,348,748
Grand Total					
Recurrent	12,348,695	11,394,887	13,567,464	42,896,974	66,093,397
Capital	1,977,316	673,935	687,006	3,963,590	4,382,761
Total	14,326,011	12,068,822	14,254,470	46,860,564	70,476,159
U Charge	315,840	399,266	406,932	1,711,855	2,378,547

*1 Integrated with TB and BPHS

Special Health Program Summary Sheet	2004	2005	2006	2007-2010	2011-2015
SHP Recurrent Costs	12,348,695	11,394,887	13,567,464	42,896,974	66,093,397
SHP Capital Costs	1,977,316	673,935	687,006	3,963,590	4,382,761
SHP Grand total	14,326,011	12,068,822	14,254,470	46,860,564	70,476,159
Possible User Charge	315,840	399,266	406,932	1,711,855	2,378,547

6.3 Improving Quality of Hospital Services

Proposed Hospital Framework for Costing:

<i>Type of Hospital</i>	<i>Average number of Beds</i>	<i>Total number of Hospitals</i>	<i>Total no of Beds in 1386 (2006) Target 80% of BPHS minimum ratios</i>	<i>Total no of Beds In 1389 (2010) Target 90%</i>	<i>Total no of Beds in 1394 (2015) Target 95%</i>
District Hospital ²⁰	50	60-93	3,017	3,804	4,649
Provincial Hospital in Provinces	100	27	1,900	2,500	2,700
Regional Hospital in Provinces	400	4	1,600	1,600	1,600
Provincial Hospital in Kabul	350	4	1,400	1,400	1,400
Regional Hospital in Kabul	400	3	1,200	1,200	1,200
Tertiary Hospitals in Kabul	400	1	400	400	400

Phasing in of secondary and tertiary Hospital beds:

	2004	2005	2006	2010/1389	2015/1394
Total Provincial Hospital beds operational in the Provinces	1700	1700	1900	2500	2700
Total Regional Hospital beds operational in the Provinces	1600	1600	1600	1600	1600
Total Provincial Hospital beds operational in Kabul	1400	1400	1400	1400	1400
Total Regional Hospital beds operational in Kabul	1200	1200	1200	1200	1200
Total Tertiary Hospital beds operational in Kabul	400	400	400	400	400

Assumptions and figures used to plan for Hospital Services. For the regional level Hospital: a 200-bed Hospital is costed. This caters for uncertainty in the expected size of regional Hospitals, and the possibility to offer e.g. two Regional Hospitals of 200 beds instead of one large 400-bed Regional Hospital. (A 200-bed Hospital is relatively more expensive than a 400-bed Hospital due to diseconomies of scale).

<i>Basic Planning Figures</i>	<i>Figure</i>
Population	22.2 Million (2003/1382)
Population Growth Rate	1.92% per year
Costing of baseline figures	(2003) US\$
<i>Hospital Cost Figures</i>	
Quantity of District Hospital Beds outside Kabul target by year 3	3,134
Quantity of District Hospital Beds outside Kabul by year 7	3,804

²⁰ The District Hospital recurrent costs are budgeted under the BPHS.

Quantity of District Hospital Beds outside Kabul by year 10	4,251
Quantity of Provincial Hospital Beds outside Kabul years 4-7	1,700 to 2,700
Quantity of Provincial Hospital Beds outside Kabul years 8-12	2,700
Quantity of Provincial Hospital Beds in Kabul years 1-12	1,400
Quantity of Regional Hospital Beds outside Kabul years 1-12	1,600
Quantity of Regional Hospital Beds in Kabul years 1-12	1,200
Quantity of Tertiary Hospital Beds in Afghanistan (Kabul) years 1-12	400
Total number of beds in Kabul (including tertiary) years 1-12	3,000
Total number of beds outside Kabul year 3	6,434
Total number of beds outside Kabul year 7	7,904
Total number of beds outside Kabul year 12	8,949
Total number of beds in Afghanistan year 3	10,434
Total number of beds in Afghanistan year 7	11,104
Total number of beds in Afghanistan year 12	11,949
Bed to 1,000 population ratio outside Kabul year 3	0.31
Bed to 1,000 population ratio outside Kabul year 7	0.36
Bed to 1,000 population ratio outside Kabul year 12	0.37
Bed to 1,000 population ratio in Kabul year 3	1.03
Bed to 1,000 population ratio in Kabul year 7	0.96
Bed to 1,000 population ratio in Kabul year 12	0.87
Medical Doctor to Bed Ratio (for all beds)	1 : 5
Medical Doctor to Paramedical Staff Ratio (for all beds)	1 : 3
Salary for Hospital Staff	Base Salary Scale for NGOs ²¹
Average cost of one Provincial Hospital Bed per year (rehabilitation) ²²	\$3,574
Average cost of one Provincial Hospital Bed per year (construction)	\$4,275
Average cost of one Regional Hospital Bed per year ²³	\$3,395
Average cost of one Tertiary Hospital Bed per year ²⁴	\$4,645
Contingency	5%
Real Discount Rate	3%
Inflation rate on capital and recurrent costs	0% per year
Inflation rate on salaries (costed in US\$)	0% per year
Annuity Factor for 20 years at the real discount rate	14.8775
Annuity Factor for 5 years at the real discount rate	4.5797
Annuity Factor for 2 years at the real discount rate	1.9135
Building Program Figures	
Baseline figure for available health clinic infrastructure in Afghanistan ²⁵	392
Total number of Comprehensive Health Centres needed for 80% BPHS by year 3	313
Total number of Basic Health Centres needed for 80% BPHS by year 3	627
Total number of Comprehensive Health Centres needed for 90% BPHS by year 7	380
Total number of Basic Health Centres needed for 90% BPHS by year 7	761
Total number of Comprehensive Health Centres needed for 95% BPHS by year 12	442
Total number of Basic Health Centres needed for 95% BPHS by year 12	883
Total number of CHC that need construction by year 3	125
Total number of BHC that need construction by year 3	275
Total number of CHC that need construction by year 7	125

²¹ National Salary Policy for Non Governmental Organizations working in the Afghan Health Sector. Final version 6 August 2003.

²² Average over 12 years; excluding initial rehabilitation or construction.

²³ *Ibid.*

²⁴ *Ibid.*

²⁵ Afghanistan National Health Resources Assessment, Ministry of Health/Management Sciences for Health. September 2002.

Total number of BHC that need construction by year 7	250
Total number of CHC that need construction by year 12	100
Total number of BHC that need construction by year 12	200
Total number of CHC that need construction year 1-12	350
Total number of BHC that need construction year 1-12	725
Total number of health centres that are needed by 1394/2015 to deliver 95% BPHS	1,325
Average cost of constructing and equipping one CHC ²⁶	\$165,000 (2003\$)
Average cost of constructing and equipping one BHC	\$90,000 (2003\$)
Baseline figure for available District Hospital infrastructure in Afghanistan ²⁷	86
Total number of District Hospitals needed in Afghanistan ²⁸	93
Quantity of Provincial Hospitals that need rehabilitation outside Kabul years 1-4	17
Quantity of Provincial Hospitals that need rehabilitation in Kabul years 1-3	4
Quantity of Regional Hospitals that need construction outside Kabul years 3-7	10
Quantity of District Hospitals that need construction outside Kabul years 1-12	35
Unit cost of construction of one 50-bed District Hospital including equipment ²⁹	\$1,150,000 (2003\$)
Unit cost of construction of one 100-bed Provincial Hospital including equipment ³⁰	\$1,716,855 (2003\$)
Unit cost of rehabilitation of one Provincial Hospital including equipment ³¹	\$666,855 (2003\$)
Unit cost of rehabilitation of one Regional Hospital including equipment ³²	\$824,093 (2003\$)
Unit cost of rehabilitation of one Tertiary Hospital including equipment ³³	\$2,644,583 (2003\$)
Total cost construction and rehabilitation program until year 3 (2006/1385)	\$75,112,523 (2003\$)
Total cost construction and rehabilitation program year 4 - 7 (2007-2010)	\$79,859,840 (2006\$)
Total cost construction and rehabilitation program year 8 – 12 (2011-2015)	\$46,000,000 (2010\$)

6.4 Human Resource Development

Assumptions used for costing the IHS/continuous education training program:

<i>Quantity of IHS that need rehabilitation</i>	9
<i>Quantity of IHS that need building</i>	3
<i>Cost of one IHS rehabilitation</i>	\$500,000
<i>Cost of one IHS construction</i>	\$2,000,000
<i>Average cost of one Mamor (simple staff) per year</i>	\$720
<i>Average cost of one Faculty member per year</i>	\$6,000
<i>Average cost of one worker per year</i>	\$1,560
<i>Average number of students per year Kabul IHS</i>	960
<i>Average number of students per year Provincial IHS</i>	480
<i>Annuity factor for 2 years at the real discount rate</i>	1.9135
<i>Annuity factor for 5 years at the real discount rate</i>	4.5797
<i>Inflation for salaries</i>	0%
<i>Inflation for other costs</i>	0%
<i>Average number of workers in Kabul IHS</i>	70
<i>Average number of staff in one Provincial IHS</i>	35

²⁶ Cost figures from LBG cost estimates for the construction of a standard CHC clinic according to USAID standards. Equipment cost from Crown Agency invoice. 400 clinics, a mix between CHCs and BHCs will be built during 2003-2006 and equipped.

²⁷ *Ibid.*

²⁸ Equitably distributed; the baseline survey documented a very inequitable distribution of District Hospitals throughout Afghanistan

²⁹ Assuming \$1 M for construction; the remainder equipment.

³⁰ Assuming \$1.5 M for construction; the remainder equipment.

³¹ \$0.5 M for rehabilitation; the remainder equipment.

³² \$0.5 M for rehabilitation; the remainder equipment.

³³ \$1.5 M for rehabilitation; the remainder equipment.

Total number of midwife graduates per year	300
Total number of nurse graduates per year	664
Total number of other paramedical staff graduates per year	664
Average lengths of one midwifery course	2 years
Average length of one nurse course	3 years
Average length of one paramedical staff course	2 years

6.5 Administrative Reform and Capacity Building

Estimated number of staff in Public Administration after successful Priority Reform and Restructuring of the Ministry of Health:

Item	Av. Monthly Cost (\$)	Total Monthly Cost (\$)
Average no of prof staff after PRR Provincial Health Department	297	\$262
Average no of support staff after PRR Provincial Health Department	304	\$80
Average no of prof staff after PRR GD Policy and Planning	102	\$250
Average no of support staff after PRR GD Policy and Planning	30	\$80
Average no of prof. staff after PRR GD Health Care & Promotion	60	\$350
Average no of support staff after PRR GD Health Care & Prom.	30	\$80
Average no of prof. staff after PRR GD Admin and Management	80	\$350
Average no of support staff after PRR GD Admin and Management	30	\$80
Total professional staff after PRR public administration	539	
Total support staff after PRR public administration	394	
Total MoH staff after PRR public administration	933	

Basic costing figures and assumptions related to the Priority Reform and Restructuring (PRR) of the Ministry of Health:

Total monthly staff cost MoH public administration	\$183,772
Total annual staff cost MoH public administration	\$2,205,260
Annual inflation on salaries	0%
Annual inflation on capital cost	0%
Annual inflation on other recurrent costs	0%
Annual Staff Cost PRR GD Policy and Planning	\$334,800
Annual Staff Cost PRR GD Health Care & Promotion	\$280,800
Annual Staff Cost PRR GD Administration and Management	\$364,800
Annual Capital Cost PRR Provincial Health Department 2006	\$324,442
Average annual Capital Cost Prov Health per professional staff by 2006	\$2,748.19
Annual Capital Cost PRR GD Policy and Planning	\$280,315
Annual Capital Cost PRR Health Care & Promotion	\$164,891
Annual Capital Cost PRR Administration and Management	\$219,855
Annual other Recurrent Cost PRR Provincial Health Department 2006	\$742,011
Average annual other Recurrent Cost PRR Prov. Health per professional staff by 2006	\$1,194
Annual other Recurrent Cost PRR Policy and Planning	\$121,783
Annual other Recurrent Cost PRR Health Care & Promotion	\$71,637
Annual other Recurrent Cost PRR Admin and Management	\$95,516

Basic assumptions related to the 26,000 MoH staff on the payroll in 2003/1382:

Years 1: same quantity of staff 1.00

Year 2: 75%	0.75
Year 3: 50%	0.50
Years 4-7: 50% staff	0.50
Years 8-12: 25% staff	0.25

Basic assumptions used for the Capacity Building Program. Years 1-3 (2004-2006) will be the 'Full Program'. This consists of 100% Technical Assistance, 100% Workshops, 100% Overseas Courses and 100% Equipment. Years 4-7 (2007-2010) will be a 'Three-Quarter Program'. This consists of 75% TA; 100% Workshops, 100% Overseas Courses and 75% Equipment. Years 8-12 (2011-2015) will be a 'Half Program'. This consists of 50% TA, 100% Workshops, 100% Overseas Courses and 50% Equipment.

	Inflation	0%
Annuity factor for 2 years at the real discount rate		1.9135
Annuity factor for 5 years at the real discount rate		4.5797
International Advisor fully loaded per year MSH estimate		\$300,000
Local Advisor fully loaded per year per rough estimate		\$24,000
Years 1-3 'Full TA program'		1.00
Years 4-7 '3/4 TA program'		0.75
Years 8-12 '1/2 TA program'		0.50

7 Implementation Strategies, Institutional and Financial Arrangements

The implementation strategy of the Ministry of Health is as follows:

1. Subcontracting Non-Governmental Organizations to deliver the BPHS, while retaining a regulating, coordinating, monitoring and evaluating role;
2. Use special programs to reinforce the effect of services offered through the Basic Package; special programs are managed, predominantly, through UN agencies;
3. Secondary and Tertiary Hospitals managed through the MoH;
4. Train sufficient paramedical staff through the IHS's, especially midwives, to enable the health system to implement the BPHS;
5. Priority Reform and Restructuring of the MoH public administration to enhance effectiveness and efficiency.

Sequencing of longer term versus shorter term actions:

Urgent funding is required for the BPHS; funding that can be absorbed rapidly if made available, by the NGOs. The only restraint on implementing a fully effective BPHS is the lack of qualified female health workers, especially community midwives. The BPHS will be phased in as follows: by year three 80% of the minimum ratios implemented; by year seven 90% of the minimum ratios implemented and by year ten 95% of the minimum ratios implemented.

Special programs can be carried out immediately if sufficient funding is made available.

The MoH will take on the secondary and tertiary Hospitals. If sufficient funding is made available, 3,000 beds in Kabul and 3,300 beds in the Provinces can be taken on immediately. Facilities, staff and basic equipment is available. A Priority Reform and Restructuring of the secondary and tertiary Hospital sector would need to be carried out. This would pose a surmountable problem as a similar exercise has already been conducted in the central Ministry. The facilities in which these beds are located would need rehabilitation. The 1,000 additional provincial beds will be phased in years 6-10; two new Provincial Hospitals are planned for each year.

The twelve Institutes of Health Sciences (IHS) will aim at newly training 2,400 midwives (through two year courses), 4,700 nurses (through three-year courses) and 5,300 other paramedical staff (through two-year courses) by 2015. Nine existing IHS's will be operational as of 2004; in 2013 three additional IHS's will be built. Thousands of other health professionals will follow postgraduate training courses and continuous education courses to refresh and upgrade their skills.

Priority Reform and Restructuring for the Provincial Health Department was approved Dec 9th 2003, and the PRR for the Policy and Planning General Directorate of the central Ministry was approved in the second week of January 2004. It is planned to have two additional General Directorates in the central Ministry undergo similar reforms during 2004/1383.

Capacity building strategy; immediate and medium term.

The exact capacity building plan for the MoH has not yet been designed, although it will build on progress to-date and on-going initiatives that are giving the MoH the ability to fulfil its new

responsibilities. A working group will start work on a capacity building plan in January 2004. The probable outcome will be a mix of in-country seminars and workshops; tailor made courses for provincial and central MoH staff; a selection of overseas conferences, meetings, and training courses for MoH senior staff; on-the-job mentoring, coaching, and advising; and, material and financial support. The latter will be included as they must be combined with human resources to produce productive institutions. For a more detailed discussion of identified technical assistance needs, see annex 5.

Necessary institutional and financial arrangements and required sector reforms.

Currently, the Ministry of Health budget is managed by the Ministry of Finance (MoF). Previously, the MoH managed its own budget, which it is unable to do at the moment. The financial systems in the MoH have been evaluated.³⁴ The report came up with seven recommendations on budgeting, 12 recommendations on Accounting and Financial Reporting, one recommendation on Internal Control and one recommendation on Audit. The report also proposed a new staffing pattern for the Finance Section. A Chief Financial Officer will be seconded by the MoF to the MoH to help with installing the financial management system. A Priority Reform and Restructuring of the Administration and Management section will hopefully go a long way towards improving this vital element of the MoH public administration.

Monitoring and Evaluation.

The MoH will carry out systematic monitoring and evaluation of its programs across the country. As at present, the MoH will work with its partners to ensure objective (“third party”) evaluation and at the same time to build the needed capacity of the MoH at central and field levels.

³⁴ Appraisal Report on Financial Systems in the Ministry of Health, Oxford Policy Management, December 2003.

8 Development Program and Budget

Afghanistan is in the early post-conflict rehabilitation phase. After more than twenty years of war, human and social capital has been eroded and destroyed. The health sector reflects the disruption of the role of the state in health service provision and the impact of over twenty years of humanitarian aid efforts.

The past two years however, have seen the evolution of a solid foundation on which a new Health System can be built. Major Health Policies and Strategies have been formulated, and donors have been coordinating their efforts to a very large extent with the Ministry of Health, who is widely seen as the steward of the Health System.

The overall design of the Health and Nutrition Sector Development Program and Budget for the next twelve years is focused on achieving two Millennium Development Goals (MDGs). These Goals are:

Target 5: Reduce by two-thirds, between 1990 and 2015, the under-five mortality rate; the current under-five mortality rate is 257/1,000;

Target 6: Reduce by three-quarters, between 1990 and 2015, the maternal mortality ratio; the current Maternal Mortality Ratio is 1,600/100,000 life births.

Afghanistan has a very high baseline; both the Child Mortality and Maternal Mortality are among the highest in the world. A survey on maternal mortality conducted in 2002, found that in Badakhshan province, the maternal mortality was as high as 6,507/100,000 life births, the highest ever recorded figure.

The two MDGs can never be reached without a considerable injection of international donor monies. However, to assess the financial sustainability of the Development Program, the overall costs by 2015/1394 are put into perspective by comparing these with the expected Public Health Budget originating from the Government's domestic resources. For this assessment, it is assumed that:

1. The 2015/1394 GDP will have reached \$450 (2015 US\$) per capita per year;
2. That the Government's own contribution to the health sector will amount to 1-1.5% of the GDP;
3. That 50% of the overall health budget by 2015/1394 will be funded by international donors (a situation not unlike that in other very poor countries).

Using the lower (1%) share of the GDP accruing to the Health Sector, the total budget available to Health would be 238.5 M \$ (2015 US\$). Using the higher share (1.5%) would lead to a total budget of 375.75 M \$ (2015 US\$).

The proposed health sector program, by year 12 (2015/1394), will cost an estimated 269.5 M \$ (2015 US\$).³⁵ This forecast indicates that, even when given the lower share (1%) of the expected

³⁵ This costing has applied (i) an annual inflation rate of 1.5% to salaries, (ii) an annual inflation rate of 3% on capital costs and (iii) an annual inflation rate of 3% to other recurrent costs.

GDP, the Health and Nutrition Sector program is financially sustainable with a 50% donor contribution.

The Health and Nutrition Sector has five sub-programs:

- (1) Basic Package of Health Services
- (2) Special Programs
- (3) Improving Quality of Hospital Services
- (4) Human Resource Development
- (5) Administrative Reform and Capacity Building

8.1 Basic Package of Health Services

The new Afghan Ministry of Health (MoH) framework, called the Basic Package of Health Services (BPHS), has four layers and consists of:³⁶

- One Health Post per 1,000-1,500 Afghans; the first layer.
- One Basic Health Centre per 15,000-30,000 population; the second layer;
- One Comprehensive Health Centre per 30,000-60,000 population; the third layer;
- One 50-bed District Hospital per 100,000-300,000 population; the fourth layer;³⁷

Afghanistan figures at the bottom of the Human Development Index. Afghanistan's health indicators such as the Child Mortality Rate (257 deaths per 1,000 children; one in four Afghan children die before reaching the age of five years) and the Maternal Mortality Ratio (1,600 women die due to causes related to childbirth per 100,000 live births) are one of the worst in the world. Apart from resource constraints, trained female health staff, especially trained community midwives, are absent in rural remote areas and would need to be trained at a considerable space to enable the Health System to staff its rural clinics.

The Ministry of Health has chosen to subcontract Non Governmental Organizations as its main strategy to implement the Basic Package of Health Services. This is a new strategy for Afghanistan, in which the state used to be the main provider of health care services. Instead of being the main service provider, to a large extent, the MoH will take on new roles and tasks that involve Regulating, Coordinating, Monitoring and Supervising NGOs and the private sector.

The planning for the implementation of the BPHS is thoroughly equitable; instead of planning for massive secondary and tertiary hospitals, especially in Kabul, the MoH has decided to secure funding for the BPHS and to design a lean and efficient secondary and tertiary hospital system (see further under 'Improving Quality of Hospital Services'). The projected resource allocation for service delivery for 2015 will be 87% for the BPHS and 13% for secondary and tertiary Hospitals (\$134.53 M for BPHS versus \$20.92 M for secondary and tertiary Hospitals). If this situation materializes 12 years down the line, it will be in stark contrast to the situation in other very poor countries, in which frequently, up to 60% of the Health recurrent budget is consumed by the Hospital sector.

³⁶ A Basic Package of Health Services for Afghanistan, Transitional Islamic Government of Afghanistan, Ministry of Health, March 2003/1382.

³⁷ The first level referral hospital.

Basic Curative and Preventive Services will be provided to Afghans with a focus on women and children. The BPHS is designed with an eye on resource constraints; it is not a luxurious package at all, however, it contains some of the most cost-effective treatments that are known to mankind. Some of these are: immunization against common childhood illnesses, treatment of diarrhoea and cough and cold, provision of Vitamin A, treatment for worms, treatment for Tuberculosis and pre and post natal care.

The BPHS has been costed.³⁸ The total cost, based on a population of 300,000 Afghans, is estimated at \$4.55 (2001) per capita per year. The cost of the first layer is estimated at \$1.13 per capita per year, the second and third layers are estimated at \$2.41 per capita per year, and the cost of the fourth layer, the Community Based Health Care (CBHC) system, is estimated at \$1.01 per capita per year.

International calculations point at a cost of delivering a package of essential services of \$12 per capita per year (\$1991), up to \$34 per capita per year (\$2001).³⁹

The costing of this BPHS, of \$4.55 per capita per year in 2001 US\$, is fairly accurate; the evidence so far, with the costing of Province wide interventions, points at an average cost of about \$3.80 (2003 US\$) per capita per year to deliver the minimum BPHS ratio. For interventions that cover districts, or clusters of districts, this cost does not hold; far higher sums are needed for this type of intervention.

Currently, only about 40% of the population, or 8.88 M, is covered by this BPHS. The reason for this is lack of monies; only about \$42.9 M is available for 1383 (2004) to deliver the basic package, whilst \$87.38 M would be necessary to reach the target of 80% of the BPHS provided to the Afghan population (see annex 3 Detailed Costing Calculations and Tables).

The targets for implementing the minimum ratios of the BPHS are: 80% for year 3; 90% by year 7 and 95% by year 10.

In year 1385 (2006), \$0.25 per capita will be added to pay for community based disability and mental health care. This sum is a guesstimate informed by an absolute lack of monies. This small sum would still provide \$4.7 M per year for these second tier components of the BPHS.

For the first three years \$323.01 M is necessary to provide 80% of the Afghan population with the BPHS; there is a funding shortfall of \$178.38 M for the first three years. For the first 12 years, the total funds required delivering the BPHS will be \$1,519.96 M.⁴⁰

The expansion of the BPHS will have to be accompanied by a well-planned construction programme for Health Centres and District Hospitals. The September 2002 National Health Resources Assessment found 86 District Hospitals and 392 Health Clinics with purpose built structures. Most facilities were ill-distributed. Thirty five 50-bed District Hospitals, 350 Comprehensive Health Centres and 725 Basic Health Centres will have to be constructed over a

³⁸ Costing of the Basic Package of Health Services for Afghanistan, Management Sciences for Health, March 31, 2003.

³⁹ World Development Report; Investing in Health. World Bank 1993 and Commission on Macroeconomics and Health (CMH), WHO December 2001.

⁴⁰ This costing assumes that there will be a 0% annual inflation on the dollar and a 1.92% population growth rate. In addition, this costing includes capital investments in constructing the service delivery network; rural 1,075 rural Health Clinics and 35 first level referral hospitals.

10 year period in order to meet the service delivery targets. Four hundred clinics are planned to be constructed over the coming three years (for which funding has been identified), many more are needed over the coming 10 years.

Budget for Implementation of the BPHS 2004/1383-2015/1394

The Capital Costs include initial equipping of the facilities; the recurrent cost related to maintenance and replacement is budgeted under the BPHS.

<i>Item</i>	<i>2004/1383 (M US\$)</i>	<i>2005/1384 M (2003US\$)</i>	<i>2006/1385 M (2003US\$)</i>	<i>2007/1386 - 2010/1389 M (2003US\$)</i>	<i>2011/1387 - 2015/1394 M (2003 US\$)</i>
BPHS	87.38	89.05	95.46	450.60	645.22
Capital Costs (construction) CHCs (QTY)	8.25 (50)	8.25 (50)	4.12 (25)	20.63 (125)	16.50 (100)
Capital Costs (construction) BHCs (QTY)	9.00 (100)	9.00 (100)	6.75 (75)	22.50(250)	18.00 (200)
Capital Costs (construction) District Hospitals (QTY)	0	0	5.75 (5)	23.00 (20)	11.50 (10)
Grand Total	104.63	106.3	112.08	516.73	676.22

8.2 Special Programs

- (a) Expanded Programme on Immunization (EPI)
- (b) Malaria and Leishmaniasis
- (c) Public Nutrition
- (d) Tuberculosis
- (e) Emergency Preparedness and Response
- (f) HIV/AIDS

(a) Expanded Programme on Immunization

The Expanded Programme on Immunization (EPI) has four objectives; first, to Eradicate Poliomyelitis (Polio), second to Eliminate Tetanus, third to Reduce Measles Mortality and Morbidity and four, to Sustain Immunization gains in Afghanistan.

Polio Eradication: The world is close to reaching the goal of polio eradication. Transmission of wild poliovirus remains only in four countries; Niger, India, Pakistan, and Afghanistan. Of these countries Afghanistan is making significant progress in polio eradication. With continued support of the international community, interruption of wild poliovirus transmission in Afghanistan will take place soon.

Polio eradication campaigns during the past couple of years have managed to reach more than six million children aged less than five years (at least 95%) in each round of National Immunization Days (NIDs) in Afghanistan. The number of confirmed polio cases has reduced dramatically (from 150 cases in 1999 to seven cases in 2003).

Vitamin A supplementation has been administered to children aged between 6-59 months twice a year during the NIDs. The number of children given supplemental doses of Vitamin A has increased from 4.3 million in May 2001 to over 5.2 million in April 2003. This intervention alone is estimated to have decreased the under- 5 mortality by 15-20%.

Tetanus Elimination: Beside routine EPI, NIDs, and Measles campaigns, the Ministry of Health developed a three year (2003-2005) Plan of Action to eliminate the maternal and neonatal tetanus from Afghanistan with the technical and financial support from UNICEF and WHO. As a pilot scheme, close to a million (838,299) women of child bearing age were targeted with three doses of Tetanus Toxoid (TT) Vaccine in 2003 in four major cities (Kabul, Mazar, Jalalabad and Kandahar) and 8 rural districts of Kabul province. This will increase the protection of mothers and their newborns from the silent but deadly tetanus. The first or pilot phase of the campaign for maternal and neonatal tetanus elimination started in February 2003 with enthusiastic backing from President Hamid Karzai. In a televised message he appealed to all women of childbearing age to receive TT vaccinations during the campaign. In 2003, more than 90% of the targeted women were vaccinated with 3 doses of TT. Due to the very encouraging coverage the Ministry of Health decided to conduct countrywide TT campaigns in 2004 covering 4 million women of childbearing age (WCBA).

Reduce measles mortality: In Afghanistan a country wide measles mortality reduction campaign was conducted in 2002. Approximately 11.5 million children aged between six months and 12 years have been immunized against measles, saving an estimated 30,000 lives annually. In 2003, 5.4 million children aged between nine months to 59 months received measles vaccines during the month of June. Preliminary data from EPI surveillance sites indicates a significant reduction in the number of reported measles cases (3,609 cases in 1999 to only 718 cases in 2003).

Achieve and sustain routine coverage: During 2002 and 2003 progress has been made towards rebuilding the structure of EPI to provide regular vaccination to Afghan women and children. New fixed centres have been established to bring EPI services closer to communities, along with the training of vaccinators. Also, some outreach activities have been established to regularly deploy vaccinators in poorly served districts. At the end of 2003 more than 800 fixed sites established compared to 385 in 1999. They are located in all provinces and most of the districts. More than 1,400 vaccinators have been trained and dedicated to providing immunization services throughout the country. There has been increased trend of coverage observed between the years.

OBJECTIVES

(1) Eradicate Poliomyelitis

<i>Sub-project objective</i>	<i>Expected results 2004-2006</i>	<i>Expected results 2006 -2010</i>
To interrupt wild polio virus transmission by 2004	<ul style="list-style-type: none"> 100% children under five will receive polio vaccine in each round of NID Indigenous transmission 	<ul style="list-style-type: none"> Zero cases of polio for consecutive three years. Eradication of polio within

<i>Sub-project objective</i>	<i>Expected results 2004-2006</i>	<i>Expected results 2006 -2010</i>
	will be stopped.	this period.
To establish sensitive AFP surveillance system.	Achieve more than 80% coverage in all the 10 AFP surveillance indicators.	Efficient surveillance system in place to detect each and every AFP cases in time.

(2) Eliminate maternal and neo-natal tetanus

<i>Sub-project objective</i>	<i>Expected results 2004-2006</i>	<i>Expected results 2006 -2010</i>
To reduce number of neo-natal tetanus case <1/1000 live births.	Vaccinate more than 90% childbearing age women with at least 3 doses of TT.	Achieve elimination status (less than one case/100 LB) in all the districts and sustain the status.
To ensure safe delivery practice in all household.	<ul style="list-style-type: none"> More than 60% of the delivery will be conducted by trained birth attendant. 	<ul style="list-style-type: none"> More than 90% of the delivery will be conducted by trained birth attendant.

(3) Reduction of measles deaths (by 95%) and cases (by 90%)

<i>Sub-project objective</i>	<i>Expected results 2004-2006</i>	<i>Expected results 2006 -2010</i>
To vaccinate all under five children with two doses of measles vaccines (Through mass campaign, catch-up and follow up campaigns).	Achieve high coverage of measles vaccination (more than 90%) to all under five children	Achieve elimination status through sustaining high coverage (more than 90%) to all under five children

(4) Achieve and sustain 80% routine vaccination coverage

<i>Sub-project objective</i>	<i>Expected results 2004-2006</i>	<i>Expected results 2006 -2010</i>
To vaccinate all under one children and complete full schedules.	Achieve 70% coverage for all the six antigens (fully immunized children).	Achieve and sustain 80% coverage for all six antigens (fully immunized children).

TARGETS

(1) Eradicate Poliomyelitis

<i>Service delivery target/indicators</i>	<i>Baseline data in 2002-2003</i>	<i>Service delivery Target for 2010</i>	<i>Service delivery Target for 2015</i>
No of polio cases in the country	10 laboratory confirmed polio cases	Zero cases for consecutive three years and eligible for certification.	Polio free Afghanistan

(2) Eliminate maternal and neo-natal tetanus

<i>Service delivery target/indicators</i>	<i>Baseline data in 2002-2003</i>	<i>Service delivery Target for 2010</i>	<i>Service delivery Target for 2015</i>
No of neo-natal tetanus cases per 1000 live birth	6 per 1000 live births.	<1/1000 live births in each and every districts of the country (achieve elimination status).	<1/1000 live births in each districts of the country (elimination status will sustain).
Number of delivery conducted by trained birth attendants.	< 15 % of all deliveries will be conducted by trained birth attendants.	>60 % of all deliveries will be conducted by qualified birth attendants.	>80 % of all deliveries will be conducted by qualified birth attendants.

(3) Reduction of measles deaths (95%) & cases (90%)

<i>Service delivery target/indicators</i>	<i>Baseline data in 2002-2003</i>	<i>Service delivery Target for 2010</i>	<i>Service delivery Target for 2015</i>
No of sentinel sites report measles cases	50% of the sites	100% of the sites will report measles cases in time.	>10 TFU training Centres
Active surveillance of measles cases in all the fixed facilities	0	>70 %	>90 %

(4) Achieve and sustain 80% routine vaccination coverage

<i>Service delivery target/indicators</i>	<i>Baseline data in 2002-2003</i>	<i>Service delivery Target for 2010</i>	<i>Service delivery Target for 2015</i>
Number of fully immunized children with all antigens	Less than 25%	>80% under one child will be fully immunized with all six antigens. (By 2005, hepatitis to be added as seventh antigen.)	Fully immunized status (>80%) will be sustained.

The following is the budget for the EPI 2004-2015

EPI	2004(1383)	2005(1384)	2006(1385)	2007-2010 (1386-1389)	2011-2015 (1390-1394)
Total Program costs (M \$)	8.72	6.15	8.07	18.14	25.06

EPI	2004(1383)	2005(1384)	2006(1385)	2007-2010 (1386-1389)	2011-2015 (1390-1394)
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Capital Costs (M \$)	1.18	0.39	0.47	2.45	2.84
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(b) Malaria and Leishmaniasis

In Afghanistan an estimated 3 million cases of malaria occur each year. The total reported cases during 2002 from the national malaria program and Non Governmental Organizations were 600,000. The reason for such an enormous gap between estimated and reported cases ought to be the disruption of the health information system and/or on the poor access to health care services.

Malaria incidence is increasing, and an estimated 60% of the population, some 17.5 million people lives in areas in which there is a risk of malaria. Outbreaks are now reported from many parts of the country, including at high altitudes where they were not previously recorded. The proportion of Falciparum infections has increased, now accounting for some 20% of recorded infections.

Although most costs related to malaria treatment are estimated in the Basic Package of Health Services, the costs for ensuring the availability of good quality Insecticide treated Bed Nets (ITNs) are estimated in this section.

Objectives and Results of Malaria Control Program

<i>Sub-project objective</i>	<i>Expected results 2004-2006</i>	<i>Expected results 2006-2010</i>
Populations at risk of malaria will have access to prompt and appropriate treatment of malaria.	Malaria morbidity reduced by 20%	Malaria morbidity reduced by 50%
Personal protection measures will be made available and affordable for high risk areas	20% of population at high risk of malaria protected by sleeping under insecticide treated bed nets	50% of population at high risk of malaria protected by sleeping under insecticide treated bed nets

Targets of Malaria Control Program

<i>Service delivery target/indicators</i>	<i>Baseline data in 2002-2003</i>	<i>Service delivery Target for 2010</i>	<i>Service delivery Target for 2015</i>
(i) % of the of health facilities reporting no disruption of stock of anti-malarial drugs for more than one week during the previous three months (ii) % of health facilities able to confirm malaria diagnosis according to the national policy (iii) % of patients with uncomplicated malaria	60% of the national populations live at risk of malaria. 26% of them live in high risk areas Current estimates suggest 3 million malaria cases occur during the 8-month transmission period (April-November) equivalent to one malaria case every 7	(i) 50% of health facilities in endemic areas receive adequate and uninterrupted flow of anti malarial drugs (ii) 50% of health facilities in endemic areas able to provide prompt, quality disease management according to the national policy	(i) 100% of health facilities in endemic areas receive adequate and uninterrupted flow of anti malarial drugs and diagnostic supplies (ii) 100% of health facilities in endemic areas able to provide prompt, quality disease management according to the national policy

<i>Service delivery target/indicators</i>	<i>Baseline data in 2002-2003</i>	<i>Service delivery Target for 2010</i>	<i>Service delivery Target for 2015</i>
getting correct treatment at health facility and community levels according to national guidelines within 24 hrs of onset of symptoms in target areas	seconds No adequate services in most endemic areas		
% of individuals and families sleep under ITNs every night throughout the transmission season	6 million nets are required to cover the entire at-risk population 500,000 nets already distributed between 1993- 2003	- Scaling-up ITNs distribution to cover 50% population at risk through subsidized selling - Pump-priming the private sector	All population living in malaria endemic areas covered by ITNs through social marketing with low subsidy or through the private sector with full cost recovery

Commitment requirements for each project already identified (1383,1384,1385,1386-89)

Malaria	2004(1383)	2005(1384)	2006(1385)	2007-2010 (1386-1389)	2011-2015 (1390-1394)
Total Program costs (M \$)	0.96	1.12	1.17	4.64	6.09

Malaria	2004(1383)	2005(1384)	2006(1385)	2007-2010 (1386-1389)	2011-2015 (1390-1394)
Capital Costs (M \$)	<i>Integrated with BPHS and TB</i>	<i>Integrated with BPHS and TB</i>	<i>Integrated with BPHS and TB</i>	<i>Integrated with BPHS and TB</i>	<i>Integrated with BPHS and TB</i>

(c) Public Nutrition

Public Nutrition and linkages to Food Security

The nutritional situation in Afghanistan is characterized by an extremely high prevalence of chronic malnutrition, also referred to as stunting which is estimated to be as 45-59%, high mortality rates among children less than five years of age and widespread occurrence of micronutrient deficiency diseases.

Despite severe food insecurity, levels of acute malnutrition or wasting remain relatively low, between 6 and 10%. Results from nutrition and health surveys suggest that women, infants less than six months and young children between 6 months and 24 months, are at particular nutritional risk in Afghanistan. The general micronutrient status of the population is poor, largely as a result of the lack of diversity of food in the diet and over-reliance on the staple food commodity wheat. Iodine deficiencies disorders are highly prevalent, particularly in mountainous provinces in the north, north-western and central highlands of the country. The prevalence of clinical cases of goitre, as reported by district-level surveys, is reported to be between 30% - 70% and access to iodized salt was estimated to be <1% during 2001. Localized data for other micronutrient deficiencies show prevalence of 50-70% anaemia among young children and their mothers and up to 20% night blindness among women. In addition, over the past few years outbreaks of scurvy have occurred repeatedly in the winter months with severe clinical signs observed in up to 10% during the winter season. The underlying causes for malnutrition, including food security, an inadequate social and care environment, a poor health environment and lack of access to health care are diverse throughout the country. For example, increasing levels of acute malnutrition or wasting are consistently reported during the hot summer season in urban areas, largely caused by a poor health environment and increase in diarrhoeal disease.⁴¹

Public Nutrition is a key priority in the overall Health Policy of the MoH. The overall goal of the MoH is “.. to reduce malnutrition of all types including micronutrient deficiency diseases through integrated and coordinated programming. In collaboration with partners, the MOH will take leadership in identifying, preventing and reducing malnutrition....”. (*Public Health Policy, April 2002 and Public Nutrition Policy and Strategy, November 2003*). The MoH will promote food and nutrition security for all by adopting a public nutrition approach involving broad-based multi-sectoral interventions that address the underlying causes of malnutrition - including food insecurity, inadequate social and care environment, inadequate access to health services and poor health environment. These policies and strategies are described in detail in the *Public Nutrition Policy and Strategy* (November 2003). Public Nutrition strategies will largely be implemented through the Basic Package of Health Services (BPHS), described by four important components of assessment, prevention and treatment of malnutrition as well as surveillance. The services delivered through the BPHS are being supported and complemented by central and provincial level interventions such as installation and establishment of eight iodizing salt factories, training centres for treatment of severe malnutrition in provincial-level hospitals and small and large-scale fortification of wheat. Legislation procedures which are underway, including the development of National Code for Marketing of Breast-milk Substitutes and legislation for Salt Iodization will further strengthen the implementation of these nutrition programmes.

⁴¹ Taken from Public Health Nutrition Policy, MoH, November 2003.

The BPHS alone is inadequate to address the malnutrition in the country therefore, mechanisms for collaboration and integration on food security including food aid, have been defined with other Ministries, specifically the Ministry of Agriculture and Animal Husbandry (MAAH) as well as the Ministry of Rural Rehabilitation and Development (MRRD).

Costing Estimation of the Public Health Nutrition Program

Commitment requirements for each project already identified (1383, 1384, 1385 and 1386-89)

Public Nutrition	2004(1383)	2005(1384)	2006(1385)	2007-2010 (1386-1389)	2011-2015 (1390-1394)
Total Program costs (M \$)	0.78	0.75	0.66	3.22	7.06

Public Nutrition	2004(1383)	2005(1384)	2006(1385)	2007-2010 (1386-1389)	2011-2015 (1390-1394)
Capital Costs (M \$)	0.1	*	*	*	*

(d) Tuberculosis

According to the WHO Tuberculosis (TB) country profile, Afghanistan is the country with the highest burden of Tuberculosis in the Eastern Mediterranean Region and one of the 22 countries in the world with the highest burden of Tuberculosis. With an estimated annual rate of infection of 2.25%, the incidence of sputum positive cases is calculated at 143 patients per 100,000 per year, and all active cases at 319 per 100,000 per year. The WHO estimates that 70,000 new cases and 20,000 deaths occur annually. In Afghanistan 65-70% of all confirmed cases are women (the reason for this is unclear).

In 2002, the Directly Observed Tuberculosis Treatment (DOTS) program covers 31% of the population, with facilities in 17 provinces. This is a generous estimate of population coverage, as having facilities in the centre of a province does not ensure access to treatment for the whole population. Expansion of the DOTS program is only way to tackle the burden of disease caused by Tuberculosis. DOTS should be delivered through the Basic Package of Health Services (BPHS), and as such represents an essential contribution to the package of basic health services offered to the Afghan people.

Most costs related to the DOTS implementation are calculated under the per capita lump sum for the BPHS; however, some costs fall outside the BPHS, i.e. TB drugs (central procurement), food incentives (WFP contributions), special training for DOTS implementation and reference laboratories. These costs are provided in this section.

Objectives and Expected Results of Tuberculosis Control Programs.

<i>Sub-project objective</i>	<i>Expected results 2004-2006</i>	<i>Expected results 2006-2010</i>
To ensure the availability of early diagnosis and quality/effective TB treatment services through the DOTS strategy in Afghanistan	Detect 70% of all expected tuberculosis cases and cure 85% of them	Detect 85% of all expected tuberculosis and cure 90% of them.

Service delivery targets of Tuberculosis Control Program

<i>Service delivery target/indicators</i>	<i>Baseline data in 2002-2003</i>	<i>Service delivery Target for 2010</i>	<i>Service delivery Target for 2015</i>
Target-1 Make DOTS available in all districts of Afghanistan	<ul style="list-style-type: none"> • 35% of all districts • 83 facilities provide DOTS services 	<ul style="list-style-type: none"> • 100% coverage among all districts. • 600 facilities provide DOTS services 	<ul style="list-style-type: none"> • Keep 100% coverage among all districts • 650 facilities provide DOTS services
Target-2 Ensure quality DOTS provision	<ul style="list-style-type: none"> • Not known • Not known 	<ul style="list-style-type: none"> • 95% of DOTS units with an uninterrupted supply of TB drugs • 95% of facilities where at least one staff has been trained (or re-trained) on DOTS in the last year 	<ul style="list-style-type: none"> • 100% of DOTS units with an uninterrupted supply of TB drug • 100% of facilities where at least one staff has been trained (or re-trained) on DOTS in the last year

Budget for 2004-2015

TB	2004(1383)	2005(1384)	2006(1385)	2007-2010 (1386-1389)	2011-2015 (1390-1394)
Total Program costs (M \$)	1.13	1.37	1.42	7.28	9.03

TB	2004(1383)	2005(1384)	2006(1385)	2007-2010 (1386-1389)	2011-2015 (1390-1394)
Capital Investment (M \$)	0.25	0.25	0.20	1.29	1.18

(e) Emergency preparedness and response

The Emergency Preparedness and Response Special Program, like the other Special Programs, is built upon the expected service delivery network and organizational arrangements that need to be available for it to function as designed.

<i>Sub-project objective</i>	<i>Expected results 2004-2006</i>	<i>Expected results 2006 -2010</i>
<ul style="list-style-type: none"> -Establish data information system on disaster management in health sector -Develop and implement National strategic plan for Disaster Management in Health sector -Establish a network system in Disaster management in Health at all levels -Establish emergency medical response services/team in case of any disasters (EMS-emergency medical services with human and material resources)) -Strengthening of laboratory services for diagnosis of epidemic prone infectious diseases -Establish integrated diseases surveillance system - Provision of essential drugs and supplies for emergencies -Rising of awareness and advocacy in emergency preparedness, mitigation and response: Decrease the vulnerability of population to any hazards and disasters through health education 	<ul style="list-style-type: none"> Conduct a survey and collect baseline data on prevention, mitigation, preparedness and response to main hazards and disasters at national level -Finalized National strategic plan for Disaster Management in Health sector -Established provincial Emergency Preparedness and response (EPR) units within the PHC framework at provincial level -Establish emergency medical response services/team in case of any disasters at National level -Establishment of lab services for diagnosis of epidemic prone infectious diseases within provincial public health laboratories in the main provinces -Develop a training manual on integrated diseases surveillance system and its methodology and conduct nationwide training -Provision of essential drugs and supplies for emergencies. To support MOH to establish medical contingency stock at National level in coordination with other stakeholders -Develop or adapt training materials and conduct training program for health professionals and policy makers 	<ul style="list-style-type: none"> -- Implement the strategic plan in health sector in coordination with the National Department of Disaster Management (DDM) -Established provincial Emergency Preparedness and response (EPR) units within the PHC framework at district and community levels -Establish emergency medical response services/team in case of any disasters at provincial level -Establishment of lab services for diagnosis of epidemic prone infectious diseases within provincial public health laboratories in all provinces -Implement the standard guidelines and protocols on integrated diseases surveillance and establish reporting, recording and dissemination system -Provision of essential drugs and supplies for emergencies. To support the MoH to establish medical contingency stock at provincial level in coordination with other stakeholders -Develop or adapt training materials and conduct training program for the public and medical academic institutions

Targets of Health Emergency Preparedness, Mitigation and Response in Afghanistan

<i>Service delivery target/indicators</i>	<i>Baseline data in 2002-2003</i>	<i>Service delivery Target for 2010</i>	<i>Service delivery Target for 2015</i>
Base line/ target-1 Strengthening of emergency preparedness, mitigation and response activities: Number of trained people, developed/adapted guidelines and standards	6 WHO staff member and 1 MoH received 2 weeks training in Iran	All provincial MoH focal points and emergency team (5-10 medical professionals) from each major hospital will be trained on EMS and public health in complex emergencies	Training program to be continued for all medical professionals and emergency volunteer team from the community
Base line/ target-2 -Information dissemination and public awareness enhancement on Disaster Management (natural and man-caused disasters and epidemic prone diseases) -Strengthen and establish integrated diseases early warning surveillance system in prevention, mitigation, preparedness and response to any disasters. Indicators: human and material resources	-Training program in health/hygiene and environmental health for women to enhance their role in EPR and decrease their vulnerability to any hazards and disasters 100 ToT trained from MOWA and 900 women trained from the community to provide a community based health education -Such system is not yet established. There is a system for different infectious diseases, but it not integrated and not implemented in all areas.	-Such training program should be expanded and sustained. The training module will include disaster management issues -Train health professionals and establish information/data and communication system at national and regional levels	-Such program should be implemented in school curriculum -Same at all provincial and district, village levels

Budget for 2004-2015

	2004(1383)	2005(1384)	2006(1385)	2007-2010 (1386-1389)	2011-2015 (1390-

					1394)
Total Program cost (M \$)	0.98	0.57	0.58	2.52	3.35

	2004(1383)	2005(1384)	2006(1385)	2007-2010 (1386-1389)	2011-2015 (1390-1394)
Capital cost (M \$)	0.42	0.01	0.01	0.18	0.22

(f) HIV/AIDS

No data on the prevalence of HIV/AIDS or other sexually transmitted infections (STI) are available due to absence of surveillance in Afghanistan. The estimated number of adults (15-49 years old) living with HIV is below 0.01% at the end of 1999.⁴² The Central Blood Bank in Kabul reports that there are 15 HIV sero-positive cases to date.⁴³ While this is a relatively low number the statistics are unreliable and do not present a realistic figure.⁴⁴

Out of the 15 known HIV positive cases 7 HIV sero-positive cases were reported during the current year [2003]. Six of these cases were among local residents who had not travelled out of the country. The earlier cases were detected among persons who had lived outside the country. The route of infection reported in these cases was heterosexual transmission. The infection pattern of STIs in Afghanistan is also unclear due to lack of relevant research.

The table below provides data on HIV/AIDS testing from the International Committee of the Red Cross (ICRC) selected hospitals in the country.

HIV testing data from hospitals supported by the ICRC:

Year	Total Hospitals	Number of tests performed	HIV positive
1996	5	7,563	0
1997	5	8,980	0
1998	6	12,168	0
1999	6	13,081	1
2000	6	13,123	2
2001	11	16,896	0
2002	12	11,719	0
2003 (JAN-MAR)	11	2,495	0
Total		86,025	3

[Source: ICRC]

Afghanistan is considered to be a country of low HIV prevalence but at high-risk for spread of HIV infection. The reasons behind this are several: over two decades of protracted armed conflicts, the extremely low socio-political and economic status of women, huge numbers of people displaced internally and externally, the extremely poor social and public health infrastructure, drug trafficking, use of injecting drugs and lack of blood safety practices. These risk factors lead officials to warn of the urgent need for early interventions to prevent a potentially rapid spread of HIV in Afghanistan.

(i) Drug abuse: Afghanistan is one of the world's largest producers of opium. Opium and heroin abuse appear to be more severe in areas where those drugs are produced. Although there is currently no data on the number of Afghans who inject drugs, indicators suggest there are

⁴² UNAIDS & WHO epidemic update. July 2002, Geneva.

⁴³ Verbal information provided by Dr. Nauman Hekmat during mission meeting.

⁴⁴ IRIN HIV/AIDS Plus news Service. Health Workers fear HIV/AIDS epidemic in Afghanistan 17 April 2002.

an increasing number of drug users in areas such as Kabul, Gardez, Farah and Herat. Recent reliable reports from Gardez of Paktia provinces suggest that there are over 100 intravenous drug users.

(ii) Unsafe blood supply: The poor state of blood transfusion facilities throughout the country is of primary concern in the control of the spread of HIV/AIDS. An estimated half of the country's 44 hospitals that perform surgery do not systematically test the blood for HIV before transfusions. According to information obtained from the Central Blood Bank and WHO, less than 30 percent of transfused blood is screened.

(iii) Refugees and internally displaced persons: Refugees and internally displaced persons are particularly vulnerable to HIV for various reasons, including exposure to sexual abuse, violence, and lack of access to information and education.

(iv) Sexually transmitted infections (STI): there are no confirmed data on STI prevalence in the country. However, information from clinical records particularly from private clinics in large towns suggests that there possibly is a high prevalence of sexually transmitted infections.

(v) Condom use The 2003 MICS (Multi Indicator Cluster Survey) reports a current use of contraceptive by 10 percent of married women in national average and 5.9 percent in rural average. Although condoms are available through Mother and Child Health (MCH) clinics, in pharmacies as well as in shops, condom use is reported to be very low and injections appear to be the most common contraceptive.

(vi) Gender aspects: Women's health is extremely poor due to malnutrition, frequent pregnancies without basic care or trained delivery assistance, and lack of access to information or services. The March 2002 Afghanistan ECOSOC report⁴⁵ paragraph 21 on violence against women and girls, its consequences and causes discusses instances of rape, sexual assault, forced prostitution and forced marriage. The civil war and militarization of society led to an increase in the number of abductions of young girls and women by fighters. It is difficult to obtain exact numbers as families have been reluctant to come forward and report cases of abductions due to the social stigma attached to a daughter or sister kidnapped or sold for sex. 54 percent of girls under the age of 18 were married.

HIV/AIDS though currently not among the most pressing public health priorities in Afghanistan is being given attention by the Ministry of Health as a potential danger. Based on the situation analysis and a preliminary assessment conducted prior to developing the National Solidarity Programme (NSP), the following priority intervention areas have been identified:

- **Surveillance and research**
- **Prevention of HIV/AIDS (Information Education Communication and Behaviour Change Communication) targeting:**
 1. Vulnerable groups (young people, women, Injection Drug Users, Internally displaced people and refugees, mobile labour force, commercial sex workers).
 2. Workers (at different industries e.g. mine industry).
 3. General population.
- **Prevention and effective management of Sexually Transmitted Infections.**

⁴⁵ Discrimination against women and girls in Afghanistan. Economic and Social Council 4-15 March 2002. Report of the Secretary General.

- **Blood Safety.**
- **Voluntary counselling and testing, care, treatment and support.**

The aforementioned priorities are addressed through eight objectives and specific intervention strategies.

Objectives and Expected Results of STI/HIV/AIDS Control Program

<i>Sub-project objective</i>	<i>Expected results 2004-2006</i>	<i>Expected results 2006 -2010</i>
<ul style="list-style-type: none"> • To reduce risk of HIV infection among vulnerable, specifically youth and high risk groups. • To reduce the risk of infection amongst the general population through an increase in awareness levels. • To reduce prevalence prevents transmission of sexually transmitted infections as part of the efforts to reduce HIV transmission. • To reduce the risk of transmission of HIV and other blood borne infections through blood transfusion. • To improve quality of life for people living with HIV/AIDS through the provision of quality care and support. 	<ul style="list-style-type: none"> • Establish a nation wide HIV/AIDS surveillance system (at least one sentinel surveillance site in each province) • Understand risk behaviours among high risk groups and youth through appropriate research measures. • Enable members of vulnerable and high risk groups to protect themselves and their peers from HIV infection. • At least in major cities, provided effective, needs based, and user-friendly STI/HIV/AIDS related services for vulnerable and high-risk groups. 	<ul style="list-style-type: none"> • National wide social marketing of condom for STI/HIV/AIDS prevention is taken place. • Still keep low prevalence rate among high risk groups, and very low prevalence rate in general populations. • Decrease at least 50 % of risk behaviours among high risk groups and youth through behaviour change communications. • At least 50% of Persons living with AIDS can receive counselling, quality care and support system through the public or any other formal/informal/private health care systems.

Service Delivery Targets of STI/HIV/AIDS Control program

<i>Service delivery target/indicators</i>	<i>Baseline data in 2002-2003</i>	<i>Service delivery Target for 2010</i>	<i>Service delivery Target for 2015</i>
Base line/ target-1 <ul style="list-style-type: none"> •To expand the knowledge base in order to facilitate planning, implementation and evaluation of STI/HIV/AIDS programmes. 	Base line <ul style="list-style-type: none"> • 11 hospitals have participated in the surveillance. 	Target <ul style="list-style-type: none"> • All provincial hospitals can be sentinel site, and report to MoH regularly. 	Target <ul style="list-style-type: none"> • All provincial hospitals, all Emergency Obstetric Care centres and STI clinics can be sentinel site, and report to the MoH regularly. • 100% of district hospitals and 80 % of
Base line/ target-2	<ul style="list-style-type: none"> • 11 hospitals can 		

<ul style="list-style-type: none"> Establish safe blood transfusion services in all national and provincial hospitals. <p>Base line/ target-3</p> <ul style="list-style-type: none"> Establish anonymous VCT (voluntary counselling and testing) centres. <p>Base line/ target-4</p> <ul style="list-style-type: none"> Establish STI/HIV control, care, and support service systems 	<p>do blood screening test.</p> <ul style="list-style-type: none"> Currently no service is rendered Currently no service is rendered 	<ul style="list-style-type: none"> 100% of national and provincial hospitals provide blood screening services and safe blood supply. Establish voluntary counselling and testing (VCT) centres in Kabul and several major cities At least, 80% of provinces have STI/HIV/AIDS control, care, and support service systems in integration manner 	<p>comprehensive centres have blood screening services and safe blood supply.</p> <ul style="list-style-type: none"> Increase number of VCT centres with integration with existing health/public/private structures. 100% provinces have STI/HIV/ AIDS control, care, and support service systems.
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Commitment requirements for each project already identified (1383,1384,1385,1386-89)

STI/HIV/AIDS	2004(1383)	2005(1384)	2006(1385)	2007-2010 (1386-1389)	2011-2015 (1390-1394)
Total Program costs (M \$)	1.76	2.11	2.36	11.06	19.89

STI/HIV/AIDS	2004(1383)	2005(1384)	2006(1385)	2007-2010 (1386-1389)	2011-2015 (1390-1394)
Capital Investment (M \$)	0.03	0.03	0.01	0.05	0.15

8.3 Improving Quality of Hospital Services

The Hospital sector in Afghanistan is in a poor condition. It has not attracted any major funding for its recurrent costs, bar funds channelled through the government system, which was composed largely of a salary component. Haphazard donor efforts have rehabilitated and equipped some of these Hospitals, most of them in Kabul. However, such efforts resemble rather well meant symbolic gestures from Embassy donor representatives than a serious and well-planned effort to lift this sector out of its miserable existence.

Distribution of beds is severely skewed. 3,190 in Kabul (Dr Shukuhmand, verbal communication) and 4,292 outside Kabul;⁴⁶ there is also a 400-bed Military Hospital; a 100-bed Police Hospital and a 150-bed Security forces Hospital in Kabul (these are outside the MoH structure).

A national Hospital Taskforce is working on drafting a National Hospital Policy, and although the Policy is not yet finalized, progress has been made. A large nationwide Hospital Survey has been conducted, taking as its starting point data that had been acquired during the September 2002 National Health Resources Assessment. Information on the results is expected to be available in January 2004. Creating a package of Essential Hospital Services is one of the objectives of the Hospital Taskforce. Such a package would take time though to create, and to cost.

As cost figures are urgently needed for the costing of the Hospital Sector for the coming 12 years, the MoH has made progress with support from the WHO, to design a generic Hospital classification. Existing Hospitals were taken as a starting point, in order to estimate the costs related to the Secondary and Tertiary Hospitals in Afghanistan.

There are four generic levels of Hospitals in Afghanistan:

1. District Hospitals (the first level referral Hospital from the Basic Package of Health Services); on average with a 50-bed capacity;
2. Provincial Hospitals, on average with a 100-bed capacity;
3. Regional Hospitals, on average with a 400-bed capacity;
4. Tertiary Hospitals; on average with a 400-bed capacity.

The existing bed to 1,000 population ratio is severely skewed towards Kabul. The National Health Resources Assessment carried out in September 2002, found a bed to 1,000 population ratio of 1.28 in Kabul versus 0.22 in the provinces. The survey also documented a patchwork of degrees of quality, related to whether or not the Hospital was supported by outside agencies. The relatively high bed to population ratio in Kabul is still reflected in the staffing patterns of the MoH; about half of the 26,000 odd staff on its payroll is based in Kabul.

The eight MoH Kabul Hospitals are so-called 'Special Care Hospitals'; each has some kind of specialty, for instance, paediatric care, chest medicine and the like. None of these Hospitals are currently functioning well due to inefficiently low salary levels and lack of resources at all levels. Patients who visit these Hospitals are frequently subject to informal payments and have to purchase their own drugs and supplies in the private sector due to stock-outs in the Hospitals.

⁴⁶ National Health Resources Assessment.

A well functioning primary health care system needs a credible and well-functioning secondary and tertiary Hospital network. However, the resources that Hospitals tend to consume in poor countries prohibit the widespread use of Hospitals and inpatient care to tackle the burden of disease that predominantly ought to be treated at lower levels in the health care pyramid.

Keeping resource constraints in mind, a strategy was designed to (i) safe guard funding for the Basic Package of Health Services, (ii) to work towards greater equity in the distribution of scarce health resources, (iii) to improve the quality of Hospital services and (iv) to rationalize the secondary and tertiary level Hospital services:

- (1) A generic classification with costings for three different levels of Hospitals (Provincial; Regional and Tertiary) has been designed, and the various types of Hospital beds have been 'budgeted' for the country for the next twelve years;
- (2) The total number of Hospital beds in Kabul will be frozen at 3,000 for the next 12 years;
- (3) The total number of Hospital beds in Provincial Hospitals outside Kabul will be increased from 1,700 to 2,700 over a period of ten years and, thereafter, kept constant;
- (4) The growth of the total number of District Hospital beds, the beds in the so-called 'first level referral Hospital', will be tied to the population growth (1.92% per annum) and funding will be secured for these beds through the BPHS. The funding for the BPHS is set to grow, as the target by 2006/1385 for the BPHS is 80%, the target for the BPHS for 2010/1389 is 90% and the target for 2012/1392 is 95% of the BPHS implemented.
- (5) The costing for the secondary and tertiary Hospitals in Afghanistan is realistic; it uses certain criteria like for instance 1 MD per 5 Beds and a ratio MD to Paramedical staff of 1 to 3, combined with adequate remuneration for the staff and sufficient capital investments and budgets for recurrent costs. Appropriate technology is introduced, avoiding high cost modern devices. The envisaged changes, if implemented, will lead to a much greater effectiveness and efficiency, at an affordable cost.

This strategy, apart from containing costs, will lead to the bed to 1,000 population ratio in Kabul to drop from 1.07 to 0.87 over a twelve year period, whilst the ratio outside Kabul will increase from 0.32 to 0.37 over the same period. A bed to population ratio of 1.07 (or, let alone, 0.32) is very low compared to the situation in other very poor countries.⁴⁷

The proposed increase in the number of Provincial Hospital beds from 1,700 to 2,700 will need construction of ten 100-bed Provincial Hospitals. Ten provinces do not have a provincial Hospital; the remaining provinces do have such a facility (17 province centres and 5 regional centres). The construction of these provincial Hospitals will take place during 2006 to 2010; two provincial Hospitals are planned in each year.

Capital, staff and other recurrent expenditures related to improving the Quality of Hospital Services are provided in the table below. (Capital Costs include the rehabilitation and equipping of all facilities and the construction and equipping of ten provincial Hospitals. After rehabilitation or construction and initial equipping, the capital cost part of the facilities includes maintenance and replacement of equipment).

<i>Costs</i>	<i>2004/1383</i> <i>M US\$</i>	<i>2005/1384</i> <i>M</i>	<i>2006/1385</i> <i>M</i>	<i>2007/1386</i> <i>-</i>	<i>2011/1390</i> <i>-</i>
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⁴⁷ Most very poor countries have a Hospital bed to 1,000 population ratio of less than 2 (versus 8 for OECD countries), out of 47 very poor countries the mean was 1.45 beds per 1,000.

		<i>(2003) US\$</i>	<i>(2003) US\$</i>	<i>2010/1389 M (2003) US\$</i>	<i>2015/1394 M (2003) US\$</i>
Capital	29.78	3.47	6.94	29.09	20.73
Staff	6.21	6.21	6.46	28.34	37.37
Recurrent	7.71	7.71	8.03	35.29	46.49
Total	43.70	17.40	21.43	92.75	104.59

8.4 Human Resource Development

More than two decades of war and chaos has left Afghanistan's health care system completely devastated both at the infrastructural and at the Human Resources level.

The most critical element in health care delivery in any country is both the quality and quantity of its Human Resource pool. Upon completion of several surveys, and much diligent data analysis, a human resource strategy has been drafted by the ministry of health of the transitional government of Afghanistan. The human resource policy centres around delivery of health care equitably through out the country, thus increasing the numbers and quality of these health care workers, especially in rural areas.

To this end the MoH budget, as it pertains to Human Resource Development, is focused on three main areas:

- 1) Institute of Health Sciences (IHS)
- 2) Continued education
 - i. Refresher / in-service education—
 - ii. Post graduate programs
 - iii. Development of national health professionals counsel
 - iv. Management training
 - v. Pre-service Training
- 3) Staff of the ministry of Health.

IHS centres are created for training nurses, midwives, and other paramedical staff, and the plan is to, over the next twelve years, have twelve fully functional IHS centres in order to have 10,000 fully trained nurses, midwives and other paramedical staff. The nine centres that are partially functional at this point will have to be rehabilitated at an average cost of \$500,000, and the remaining three to be built from the ground up by the year 2013, at an estimated cost of \$2 million dollars each.

Intermediate Health Sciences Institutions					
	2004	2005	2006	2007-2010	2011-2015
Staff cost					
Kabul IHS	\$307,200	\$307,200	\$307,200	\$1,228,800	\$1,536,000
11 Provincial IHSs	\$1,228,800	\$1,228,800	\$1,228,800	\$4,915,200	\$7,065,600
Recurrent cost					
Kabul IHS	\$1,984,800	\$1,984,800	\$1,984,800	\$7,939,200	\$9,924,000
11 Provincial IHSs	\$7,560,000	\$7,560,000	\$7,560,000	\$30,240,000	\$43,470,000
Capital Cost					
Rehabilitation eight IHSs (2004)	\$4,500,000				
Construction of three IHSs (2013)					\$6,000,000
Kabul IHS	\$150,000	\$37,655	\$37,655	\$150,619	\$188,273
11 Provincial IHSs	\$600,000	\$223,870	\$223,870	\$895,480	\$1,495,801
Total	\$16,330,800	\$11,342,325	\$11,342,325	\$45,369,298	\$69,679,674
Grand total 12 years					\$154,064,421

8.5 Administrative Reform and Capacity Building

The current number of Ministry of Health (MoH) staff on the payroll is said to be 26,000, although this number is not firm. According to one estimate, 59% of these are in Kabul and the rest outside of Kabul, although many of the rest are in the major urban centres. The distribution of staff reflects the historic arrangements and outlook within the MoH – Kabul and urban biased.

Afghanistan's health system is in a rapid state of flux. The new MoH strategy to implement the Basic Package of Health Services (BPHS) involves contracting these health services to Non Governmental Organizations (NGOs). It is likely that the MoH will be involved to a certain extent in the delivery of this basic package, however, to what extent exactly is not clear yet. The exact implications on the need for MoH Human Resources will therefore be difficult to predict twelve years from now. An additional problem is that virtually all MoH staff is based either in Kabul or in large urban centres, whilst the delivery of the basic package occurs in rural (remote) areas with scarce opportunities for schooling of children or additional income generating options (private practice).

Need for redistribution of MoH staff

Although the National Salary Policy for NGOs allows paying competitive salaries to Health Staff working in rural remote areas, it is unlikely that all MoH provincial staff will be absorbed by NGOs.

This Salary Policy has a rural hardship allowance scheme. (The scheme, which uses 11 variables, scores the relative rural hardship of rural areas; it leads to a grading system that runs from 1 to 4). The first grade, the least 'hard', is typically in either the province or the district centre. This first grading allows the NGO to pay, as a maximum-they are allowed to pay less- the Base Salary Scale. The fourth grade, allows- they are allowed to pay less- the NGO to pay a 200% allowance for female 'essential medical staff'- doctors and nurses and midwives-, and a 100% allowance for male 'essential medical staff', on top of their base salary scales.

It has to be seen what kind of impact these monetary incentives will have on the motivation of MoH staff to move from Kabul and the Provincial centres to rural remote areas. Most MoH Health Staff have some kind of economic ties to the urban centres through their private practices, the purpose of them being MoH staff, and showing up in the Provincial Hospital or some MoH

urban clinic, for a few hours each day, is to avoid losing their rights to exercise private practice. The MoH allows private practice, provided that MoH staff shows up during official working hours in MoH institutions. It goes without saying that this does not work; typically an average MoH employee would walk in about 10.00-ish, sign the attendance sheet, and leave by 13.00 hrs. Or, worse, would walk in once a week and sign for the whole week, or having others sign for him or her.

Below are four tables, representing staffing patterns correlating with service delivery targets by year 1,3,7 and 10.

Staff at the Community Based Health Care Programme Level; Community Health Workers (CHWs) and Traditional Birth Attendants (TBAs)⁴⁸, located in so-called 'Health Posts' is excluded –although they form a considerable number of Health Workers; 100% BPHS at the minimum ratio correlate with one CHW and one TBA per 1,500 Afghan Population-. The reason that they are excluded is that it they will not form part of the salary recurrent costs; they are supposed to either work free of charge or be remunerated by some sort of community financing mechanism. In addition to the staffing levels, it is important to realize that NGO Programme staff is excluded from these staffing patterns. Quite a few Health Supervisors, Trainers and Health Programme Managers will be employed by NGOs to carry out the service delivery tasks. The figures provided only reflect Health staff directly in contact with beneficiaries; the central and provincial MoH staff are excluded, equally are MoH staff excluded who are involved in various training activities, for instance in the IHS (Intermediate Health Sciences) Institute. Health Staff that is involved in the Special Programs carried out by UN agencies are also excluded. It is envisioned to integrate all these Provincial MoH staff in the current set-up, of for instance, the Provincial Health Offices. The new Priority Reform and Restructuring (PRR) of the Provincial Health Offices takes care of for instance seven Provincial Health Officers in each Province, most, if not all, involved in Special Programmes like for instance Nutrition, EPI, Reproductive Health and Save Motherhood Initiative, Communicable Diseases etc. However, as the PRR process is supposed to be about recruitment based on merit only, it is not certain if all recruited persons will be existing MoH staff.

The Total Staff in the tables is the sum total of Total Medical Staff and Total Support Staff and Administrative Staff. Other Medical Staff is the result of Medical Specialists plus MD (Male) plus MD (Female) plus Nurses plus Midwives minus Total Medical Staff (these are staff like Laboratory Technicians, X-ray Technicians, Pharmacists and the like). For interpreting the tables: it is fair to assume that the BPHS will predominantly be provided by NGOs, and that service delivery in the Secondary and Tertiary Hospitals will be taken on by the MoH.

Staffing for 2004 (1384)

⁴⁸ The inclusion of the TBAs in the BPHS is the subject of an ongoing debate.

Staffing for 2004 (1383)				Target 80% BPHS for 1385	
Staff Categories	Totals Sec and Tert H 2004 (1383)	Staff outside Kabul 2004 (1383)	Staff in Kabul 2004 (1383)	Staff BPHS for entire population 2004 (1383)	Total Health Staff for 1383 2004 (1383)
Total Staff	7,256	4,290	2,966	12,309	19,565
Total Medical Staff	5,838	3,440	2,398	7,301	13,139
Total Support Staff	1,211	729	482	4,827	6,038
Medical Specialists	520	312	208	121	641
MD (M)	470	274	196	1,026	1,496
MD (F)	470	274	196	422	892
Nurses	2,292	1,365	927	1,750	4,042
Midwives	771	422	349	1,146	1,917
Other Medical Staff	1,317	793	524	2,836	4,153
Administrative Staff	205	121	84	1,388	1,593
Total MDs	1,460	860	600	1,569	3,029
Total Paramedical	4,378	2,580	1,798	5,732	10,110

Staffing for 2006 (1386)

Staffing for 2006 (1386)			Target 80% BPHS for 1386		
Staff Categories	Totals Sec and Tert H 2006 (1386)	Staff outside Kabul 2006 (1386)	Staff in Kabul 2006 (1386)	Staff BPHS for entire population 2006 (1386)	Total Health Staff by 1386 2006 (1386)
Total Staff	7,256	4,290	2,966	12,786	20,042
Total Medical Staff	5,838	3,440	2,398	7,584	13,422
Total Support Staff	1,211	729	482	5,014	6,225
Medical Specialists	520	312	208	125	645
MD (M)	470	274	196	1,065	1,535
MD (F)	470	274	196	439	909
Nurses	2,292	1,365	927	1,818	4,110
Midwives	771	422	349	1,191	1,962
Other Medical Staff	1,317	793	524	2,946	4,263
Administrative Staff	205	121	84	1,442	1,647
Total MDs	1,460	860	600	1,630	3,090
Total Paramedical	4,378	2,580	1,798	5,954	10,332

Staffing for 2010 (1389)

Staffing for 2010 (1389)				Target 90% BPHS for 1389	
Staffing for 2010 (1389)	Totals Sec and Tert H	Staff outside Kabul	Staff in Kabul	Staff BPHS for entire population	Total Health Staff for 1385-1389
Staff Categories	2010 (1389)	2010 (1389)	2010 (1389)	2010 (1389)	2010 (1389)
Total Staff	7,256	4,290	2,966	15,521	22,777
Total Medical Staff	5,838	3,440	2,398	9,206	15,044
Total Support Staff	1,211	729	482	6,087	7,298
Medical Specialists	520	312	208	152	672
MD (M)	470	274	196	1,293	1,763
MD (F)	470	274	196	533	1,003
Nurses	2,292	1,365	927	2,206	4,498
Midwives	771	422	349	1,446	2,217
Other Medical Staff	1,317	793	524	3,576	4,893
Administrative Staff	205	121	84	1,750	1,955
Total MDs	1,460	860	600	1,978	3,438
Total Paramedical	4,378	2,580	1,798	7,228	11,605

Total staffing for 2013 (1392)

Staffing for 2013 (1392) Staff Categories	Total's Sec and Tert H 2013 (1392)	Staff outside Kabul 2013 (1392)	Staff in Kabul 2013 (1392)	Target 95% BPHS for 1392	
				Staff BPHS for entire population 2013 (1392)	Total Health Staff for 1389-1392 2013 (1392)
Total Staff	7,256	4,230	2,966	17,345	24,601
Total Medical Staff	5,838	3,440	2,388	10,288	16,126
Total Support Staff	1,211	729	482	6,802	8,013
Medical Specialists	520	312	208	170	690
MD (M)	470	274	196	1,445	1,915
MD (F)	470	274	196	595	1,065
Nurses	2,292	1,365	927	2,466	4,758
Midwives	771	422	349	1,615	2,396
Other Medical Staff	1,317	793	524	3,996	5,313
Administrative Staff	205	121	84	1,956	2,161
Total MDs	1,460	860	600	2,211	3,671
Total Paramedical	4,378	2,580	1,798	8,077	12,459

Only 2,966 MoH staff employed in the secondary and tertiary Hospital services will be Kabul based by 2015. To this number of Kabul based staff we have to add staff employed in MoH Kabul Primary Health Care activities such as Mother and Child Health Clinics, employees working in e.g. the central reference laboratory and employees working in the reformed central MoH. It is to be expected that Primary Health Care facilities in Kabul will be expanded over a 12 year period; namely; access to the BPHS ought to be for urban Afghans as well (currently the focus is on the rural Afghan population).

Priority Reform and Restructuring (PRR) of the Ministry of Health

A PRR for the Provincial Health Department, the 'Provincial Health Liaison Office and 32 Provincial Health Offices', has been approved in the Dec 9th Cabinet meeting. It involves 297 professional staff on PRR scales, some of which on an extraordinary 'Super Scale', and 324 support staff (cleaners, messengers, and drivers) on the 'U' (Unchanged) Level. 70 staff is on this Super Scale, and 227 staff on the PRR scale, on various levels.

The average monthly remuneration for these professional 297 staff will be Afs 13,340. Three large Directorates in the Central Ministry of Health will need to be 'PRR-rd'; the first of which will be the Policy and Planning Directorate.⁴⁹ The Health Care & Promotion and the Administration and Management Directorates (the latter through some national mechanism), will follow suit.

The PRR of the Provincial Health Department will lead to 13 staff in the Kabul Liaison Office and 608 staff outside Kabul. One could to assume that about 1,000 staff will be involved in various MoH clinics in Kabul, and in various Kabul departments, like for instance the national reference laboratory. After a successful PRR of the MoH public administration, 200 staff could remain. A fair assumption would be that another 500 MoH staff would be employed throughout the country at the provincial level.

It is reasonable to assume that, by 2015, the total MoH staff will be less than 10,000 based on the aforementioned assumptions. If MoH staff is not willing to assume duties in rural remote areas, then, in that case, mechanisms ought to have been put into place for transferring them to other sectors or getting them out of the civil service.

New roles and tasks for the MoH

⁴⁹ A PRR for the Policy and Planning General Directorate has been approved in the second week of January.

Since the formation of the TISA, the new roles and tasks for the MoH in the developing Afghan health system have been:

- Policy setting;
- Regulating, Coordinating, Monitoring and Evaluating;
- Human Resource Development (including IHS, continuous training programs, capacity building of senior staff through on-site technical assistance and advanced courses);
- Securing funds for the Afghan public health system;
- Service delivery through the secondary and tertiary hospitals; and,
- (Possibly) involvement in service delivery of the BPHS.

Budget for Public Administration after PRR of the Provincial Health Department

MoH staff in PRR Provincial Health Department	2004/1383	2005/1384	2006/1385
Staff cost	\$297,587	\$898,042	\$933,664
Capital cost	\$960,267	\$2,739,417	\$324,442
Other Recurrent cost	\$229,500	\$528,350	\$742,011
Total Cost	\$1,487,354	\$4,165,809	\$2,000,117

Total Budget of Public Administration after Priority Reform and Restructuring⁵⁰

MoH staff in Public Administration	2004/1383	2005/1384	2006/1385	2007-2010/1389	2011-2015/1394
Staff cost	\$297,587	\$2,170,282	\$2,205,904	\$8,823,616	\$19,853,136
Capital cost	\$960,267	\$3,404,479	\$989,504	\$3,958,016	\$8,905,536
Other Recurrent cost	\$229,500	\$817,286	\$1,030,947	\$4,123,788	\$9,278,522
Total cost	\$1,487,354	\$6,392,047	\$4,226,355	\$16,905,420	\$25,358,129

Remaining MoH staff

Currently, about 18,000 MoH staff is on the payroll. The 2003/1382 MoH budget looks as follows:⁵¹

The MoH current budget for 1382	AFS	\$
Staff cost	517,368,750	\$10,778,516
Recurrent cost	22,260,000	\$463,750
Capital cost	22,260,000	\$463,750
Total	561,888,750	\$11,706,016

The following plan will be applied to the MoH staff: in the first year, 2004, 100% of staff cost will be budgeted; in 2005, 75% of the staff cost will be budgeted, during 2006-2010, 50% of the staff cost will be budgeted; during 2011-2015, 25% of the staff cost will be budgeted. This estimation will hopefully coincide with (i) absorption of MoH staff by NGOs implementing the

⁵⁰ Excluding recurrent costs related to the remaining staff on the MoH payroll.

⁵¹ Information from the MoH Administration and Management General Directorate.

BPHS; (ii) transfer of MoH staff to other Sectors; (iii) dismissal of MoH staff who refuse to take on assignments and (iv) natural turn-over.

The budget for the remaining MoH staff looks as follows:

<i>MoH recurrent staff cost</i>	<i>2004</i>	<i>2005</i>	<i>2006</i>	<i>2007-2010</i>	<i>2011-2015</i>
Staff cost	\$10,778,516	\$8,083,887	\$4,041,943	\$16,167,773	\$13,473,145

Capacity Building

For more details see annex 5 'Technical Assistance Needs'.

The capacity building is constructed around: (i) the need for International and Local consultants; (ii) the need for tailor made courses for provincial and central public administration staff and (iii) the need for a well-designed capacity building plan for senior MoH staff, which includes overseas courses.

The Capacity Building plan is constructed around the assumption that most of the TA will be needed years 1-3, and that thereafter, the need for TA can be slowly decreased. However, workshops, seminars and overseas courses are kept at a high level throughout.

Capacity Building Program	2004	2005	2006	2007-2010	2011-2015
Staff cost international & local consultants	\$14,832,000	\$14,832,000	\$14,832,000	\$44,496,000	\$27,810,000
NGO technical assistance cost	\$2,000,000	\$2,000,000	\$2,000,000	\$6,000,000	\$3,750,000
In country training and workshops	\$704,000	\$704,000	\$704,000	\$2,816,000	\$3,520,000
Overseas conferences and meetings	\$753,600	\$753,600	\$753,600	\$3,014,400	\$3,768,000
Vehicles	\$88,000	\$19,215	\$19,215	\$93,834	\$55,244
Equipment	\$336,000	\$175,594	\$175,594	\$739,515	\$627,763
Total	\$18,713,600	\$18,484,410	\$18,484,410	\$57,159,749	\$39,531,007

Annexes

Annex 1 Detailed Background Information on Sector⁵²

<i>Basic Indicators (can be different from official CSO statistics)</i>	<i>1992</i>	<i>2002</i>
Total population (000) ⁵³		22,930
Annual growth rate (1992-2001)		3.8 ⁵⁴
Dependency ratio (per 100)	88	86
Percentage of population aged 60+ years	4.7	4.7
Total fertility rate	7	6.8
Life expectancy at birth (both sexes)	42.6	42.6

<i>Selected National Accounts Indicators</i>	<i>1997</i>	<i>1998</i>	<i>1999</i>	<i>2000</i>	<i>2001</i>
Total expenditure on health as % of GDP	1.4	1.6			
Public expenditure on health as % of total expenditure on health	52.6	57.7			
Private expenditure on health as % of total expenditure on health	47.4	42.3			
Public expenditure on health as % of general government expenditure	3.6	4.2			
Social security expenditure on health as % of public expenditure on health	0.0	0.0			
Tax funded expenditure on health as % of public health expenditure on health	92.5	96.2			
External resources for health as % of public expenditure on health	7.5	3.8			
Private insurance on health as % of private expenditure on health	0.0	0.0			
Out-of-pocket disbursements for health as % of private expenditure on health	100	100			
Per capita total expenditure on health at official exchange rate (US \$)	6	8			
Per capita total expenditure on health at international dollar rate	34	35	38	40	34
Per capita public expenditure on health at official exchange rate (US \$)	3	5	n.a.	5	4
Per capita government expenditure on health at international dollar rate	17	19	20	22	18
Per capita total expenditure on health in international dollars	9	11	n.a.	9	8
Per capita public expenditure on health in international dollars	5	6			

⁵² Taken from the (i) World Health Report 2001, WHO. Statistical annex and (ii) World Health Report 2003, statistical annex.

⁵³ CSO uses a baseline population of 22.2 M for 2003 (1382).

⁵⁴ CSO uses an annual growth rate of 1.92%. In the costing assumptions, CSO data are used.

Annex 2 Determination of Indicators and Targets

a. Sub-program Objectives and Expected Results

A Program Objectives

1. Reducing the high levels of mortality and morbidity, especially among females and the rural population, mainly through the implementation of the Basic Package of Health Services. 2. Building the human resource and institutional capacity of the MOH to fulfill its planning, leadership, and stewardship roles in the health sector and to ensure the efficient use of scarce resources.

Sub-program Objectives and Expected Results											
Solar year	1383	1384	1385	1386	1387	1388	1389				
Fiscal year	2004	2005	2006	2007	2008	2009	2010				
#	1	2	3	4	5	6	7				
	Sector Objectives			Expected Results		Expected Results					
				List major results which this sub-programme is expected to achieve during the 1383-1385 time period.]		List major results which this sub-programme is expected to achieve during the 1386 - 1389 time period.].					
Millenium Development Goals	[Summary of Sub-Programme objective]										
	1. Maternal health: Three-quarters reduction in maternal mortality rate. (2003 = 1,600 per 100,000) 2. Child mortality: Two-thirds reduction in under-five mortality rate. (2003 = 275 per 1,000)					1,000					
						150					
Subprogram 1: (e.g. road infrastructure)											
Basic Package of Health Services			The Basic Package of Health Services (BPHS) is made available to the entire population of Afghanistan.			80% of population covered		90% of population covered			
Subprogram 2:											
Special Programs (includes 1) EPI, 2) malaria/leishmaniasis, 3) public nutrition, 4) tuberculosis, 5) helminthes, 6) emergency response and preparation, and, 7)			1) To reduce vaccine preventable diseases and death through eradicating wild polio, eliminating neo-natal tetanus; reducing measles deaths, and expanding routine vaccination coverage			1) > 90% childbearing age women receive at least three doses of tetanus toxisole, and > 90% U5C receive measles vaccination;		1) Wild polio eradicated, maternal and neo-natal tetanus eliminated;			
						95% of population covered.		Polio free and keep less than 1/1000 neonatal tetanus in all districts			

b. Indicators and Targets for the Special Health Programs

<i>Expected results 2006-2010</i>	<i>Program</i>	<i>Major service delivery target</i>	<i>Baseline data in 2002-2003</i>	<i>Target for 2010</i>	<i>Target for 2015</i>
Wild polio and maternal and neonatal tetanus are eliminated	EPI	No of polio cases and neonatal cases	10 confirmed polio and 6 neonatal tetanus cases per 1,000 live births	Zero cases and less than 1/1,000 neonatal tetanus cases in all districts	Polio free and neonatal tetanus less than 1/1,000 in all districts
More than 90% of household will have access to iodized salt, and a dramatic decrease in iodine deficiency disorders, and other micronutrient deficiency disorders will occur	P Nutrition	Universal salt iodization and treatment and management of severe malnutrition	3 salt iodizing factories, nil therapeutic feeding training units (TFU) training center, and nil district TFU.	8 iodizing salt factories, 8 provincial TFU training centers and 30 district TFUs	More than 8 functioning salt iodizing factories, 10 provincial TFU training centers and 50 district TFUs
Detect 85% of all expected tuberculosis and cure 90%	TB	Make quality DOTS available in all districts of Afghanistan	35% of all districts and 83 facilities provide DOTS services	100% coverage of all districts and 600 facilities provide diagnosis/DOTS services	Keep 100% coverage and 650 facilities provide diagnosis/DOTS services
Malaria morbidity reduced by 50%	Malaria	Quality malaria treatment services available in all districts and increase availability of insecticide treated bed nets (ITNs)	No adequate services in most endemic areas, and 500,000 INTs have been distributed	50% of health facilities provide adequate malaria management, and 50% of population at risk areas use ITNs	100% of health facilities, and 80% of population at risk areas
Low prevalence rate among high risk groups, and very low prevalence rate among general populations	STI/HIV/AIDS	To establish a safe blood supply system and STI/HIV care and support service system in all provinces	11 hospitals can do blood screening tests, and currently neither VCCT nor quality STI services are available	100 % of national and provincial hospitals provide blood screening, 80% of provinces have STI/HIV services	100% of district hospitals provide blood screening services, and 100% provinces have quality STI/HIV care and treatment services

Annex 3 Detailed Costing Calculations and Tables

1. Basic Package of Health Services

The table below provides the breakdown in costs for the various components in the BPHS. It excludes capital investments related to expanding the service delivery network (construction of 1,075 rural Health Clinics and 35 first level referral Hospitals). More details on the construction programme are provided in the Development Program and Budget section.

Estimated costs of Basic Package of Health Services (1383-1394 (2004-2015)).

	1382 Year 0 Mar 03-Mar 04	1383 Year 1 2004	1384 Year 2 2005	1385 Year 3 2006	1386-1389 Yrs 4-7 2007-2010	1390-1394 Yrs 8-12 Mar 15-Mar 16
1.1 Population annual growth rate (%)	1.92%	1.92%	1.92%	1.92%	1.92%	1.92%
1.2 Population (million) CSO 1982*	22.20	22.63	23.06	23.50	25.85	27.89
1.3 Population covered (million)	8.98	16.10	16.45	16.80	23.26	26.50
1.4 % of population covered	40	80	80	80	90	95
2. Cost Estimates in per capita USD						
2.1 Inflation rate	3%	0%	0%	0%	0%	0%
2.2 Health post/Outreach services***	1.07	1.07	1.07	1.07	1.07	1.07
2.3 Basic Health Centers and Comprehensive Health Centers***	2.58	2.58	2.58	2.58	2.58	2.58
2.4 Mental Health & Disability***				0.25	0.25	0.25
2.5 District hospital services**	1.20	1.20	1.20	1.20	1.20	1.20
2.6 Per capita cost of basic package***	\$4.83	\$4.83	\$4.83	\$5.68	\$5.68	\$5.68
3. Increased percentage of facilities/population						
3.1 District hospital/population	300,000	300,000	300,000	300,000	300,000	300,000
3.2 Comprehensive Health Center/population	60,000	60,000	60,000	60,000	60,000	60,000
3.3 Basic health centers/population	30,000	30,000	30,000	30,000	30,000	30,000
3.4 Health post/population	1,500	1,500	1,500	1,500	1,500	1,500
4. Total cost estimated per year (USD million)						
4.1 Health post/Outreach services	3.51	19.40	15.77	20.85	55.10	136.17
4.2 Basic health centers and comprehensive health centers	22.70	46.28	47.17	48.07	226.32	324.33
4.3 Mental Health & Disability	0.00	0.00	0.00	4.70	22.19	31.77
4.4 District hospital services	16.55	21.70	22.12	22.54	106.40	152.35
4.5 Total cost of Basic Package of Health Services (US\$ M)	\$42.86	\$87.38	\$85.05	\$95.16	\$450.60	\$645.22

In 1982 (2003) about 40% of the population is covered by the BPHS

* CSO data 1982 used for population 22.2 million

** Population to be covered 80% upto 1385, 90% upto 1389 and 95% upto 1393

*** Costing of the Basic Package of Health Services for Afghanistan March 31, 2003

**** Mental Health and Disability 0.25 per capita is added from March 1385 onwards

2. Special Programs

(a) Expanded Programme on Immunization

Dated: 18.01.2004

		Syringe/Needle Forecast for the Year 2003-2010									
Yearly Population Projections	Year	2003	2004	2005	2006	2007	2008	2009	2010		
	Total Population	22,200,000	22,626,240	23,060,664	23,503,429	23,954,694	24,414,625	24,883,385	25,361,146		
	Under one (4% of population)	888,000	905,050	922,427	940,137	958,188	976,585	995,335	1,014,446		
	Under 5 (20% of population)	4,440,000	4,525,248	4,612,133	4,700,686	4,790,939	4,882,925	4,976,677	5,072,229		
	Pregnant Women (5% of population)	1,110,000	1,131,312	1,153,033	1,175,171	1,197,735	1,220,731	1,244,169	1,268,057		
	CBA Women (20% of population)	4,440,000	4,525,248	4,612,133	4,700,686	4,790,939	4,882,925	4,976,677	5,072,229		
Quantities required for routine EPI	BCG AD Syringe, 0.05/0.1ml, 27G, 10mm	1,065,600	1,086,060	1,106,912	1,128,165	1,149,825	1,171,902	1,194,402	1,217,335		
	Mea/DTP/TT etc. AD Syringe, 0.5ml, 23G, 25mm	6,926,400	7,059,387	7,194,927	7,333,070	7,473,865	7,617,363	7,763,616	7,912,678		
	BCG/Hib Reconstitution Syringe, 2.0 ml	66,600	67,879	69,182	70,510	71,864	73,244	74,650	76,083		
	Mea/YF Reconstitution Syringe 5.0 ml	133,200	135,757	138,364	141,021	143,728	146,488	149,300	152,167		
	Safety Box, 5 Litre (Capacity 100 syringes)	81,918	83,491	85,094	86,728	88,393	90,090	91,820	93,583		
Quantities required for SIAs activities	Mea/YF etc. AD Syringe, 0.5ml, 23G, 25mm	4,528,800	4,615,753		4,794,699				5,173,674		
	MNT AD Syringe, 0.5ml, 23G, 25mm	15,984,000	16,290,893								
	Mea/YF Reconstitution Syringe 5.0 ml	543,456	553,890		575,364				620,841		
	Safety Box, 5 Litre (Capacity 100 syringes)	210,563	214,605		53,701						
	BCG AD Syringe, 0.05/0.1ml, 27G, 10mm	82,104	96,171		119,360						
Cost as per 2004 price including freight + 10% annual increase (routine EPI)	Mea/DTP/TT etc. AD Syringe, 0.5ml, 23G, 25mm	493,852	503,334	562,643	624,044	696,190	779,637	866,031	964,555		
	BCG/Hib Reconstitution Syringe, 2.0 ml	2,298	2,342	2,625	2,919	3,223	3,538	3,949	4,375		
	Mea/YF Reconstitution Syringe 5.0 ml	5,361	5,464	6,047	6,811	7,603	8,423	9,443	10,500		
	Safety Box, 5 Litre (Capacity 100 syringes)	60,292	69,130	77,308	85,774	95,553	106,712	119,320	133,449		
	Total Routine EPI Cost	643,907	676,441	755,551	838,908	934,799	925,263	1,028,962	1,146,477		
Cost as per 2004 price including freight + 10% annual increase (SIAs)	Mea/YF etc. AD Syringe, 0.5ml, 23G, 25mm	322,903	329,103	-	408,029	-			630,671		
	MNT AD Syringe, 0.5ml, 23G, 25mm	1,139,659	1,273,948	-	-	-					
	Mea/YF Reconstitution Syringe 5.0 ml	21,874	22,294	-	27,790	-			42,838		
	Safety Box, 5 Litre (Capacity 100 syringes)	154,974	177,693	-	53,110	-			82,630		
	Total SIAs Cost	1,639,411	1,803,038	-	488,929	-			756,139		
Grand Total for Syringes		2,283,318	2,479,480	755,551	1,327,837	934,799	925,263	1,028,962	1,902,616		

Dated: 18.01.2004

		Syringe Forecast 2011-2015					
		Year					Total 2003-2015
Yearly Population Projections	Total Population	2011	2012	2013	2014	2015	
	Under one (4% of population)	25,848,080	26,344,363	26,850,175	27,365,699	27,891,120	
	Under 5 (20% of population)	1,033,923	1,053,775	1,074,007	1,094,628	1,115,645	
	Pregnant Women (5% of population)	5,169,616	5,268,873	5,370,035	5,473,140	5,578,224	
	CBA Women (20% of population)	1,292,404	1,317,218	1,342,509	1,368,285	1,394,556	
		5,169,616	5,268,873	5,370,035	5,473,140	5,578,224	
Quantities required for routine EPI	BCG AD Syringe, 0.05/0.1ml, 27G, 10mm	1,240,708	1,264,529	1,288,808	1,313,554	1,338,774	
	Mea/DTP/TT etc. AD Syringe, 0.5ml, 23G, 25mm	8,064,601	8,219,441	8,377,255	8,538,098	8,702,029	
	BCG/Hib Reconstitution Syringe, 2.0 ml	77,544	79,033	80,551	82,097	83,673	
	Mea/YF Reconstitution Syringe 5.0 ml	155,088	158,066	161,101	164,194	167,347	
	Safety Box, 5 Litre (Capacity 100 syringes)	95,379	97,211	99,077	100,979	102,918	
					5,582,603		
Quantities required for SIAs activities	Mea/YF etc. AD Syringe, 0.5ml, 23G, 25mm						
	MNT AD Syringe, 0.5ml, 23G, 25mm				669,912		
	Mea/YF Reconstitution Syringe 5.0 ml				62,525		
	Safety Box, 5 Litre (Capacity 100 syringes)		-	-			
	BCG AD Syringe, 0.05/0.1ml, 27G, 10mm	131,267	145,421	29,643	33,233	36,950	
	Mea/DTP/TT etc. AD Syringe, 0.5ml, 23G, 25mm	686,298	765,641	857,412	952,425	1,060,777	
Cost as per 2004 price including freight + 10% annual increase (routine EPI)	BCG/Hib Reconstitution Syringe, 2.0 ml	3,210	3,545	3,891	4,343	4,811	
	Mea/YF Reconstitution Syringe 5.0 ml	7,491	8,362	9,263	10,385	11,547	
	Safety Box, 5 Litre (Capacity 100 syringes)	94,330	105,085	117,357	131,223	146,761	
	Total Routine EPI Cost	922,596	1,028,053	1,017,565	1,131,609	1,260,847	12,310,979
	Mea/YF etc. AD Syringe, 0.5ml, 23G, 25mm		-		680,519	-	
	MNT AD Syringe, 0.5ml, 23G, 25mm		-			-	
Cost as per 2004 price including freight+ 10% annual increase (SIAs)	Mea/YF Reconstitution Syringe 5.0 ml		-		46,224	-	
	Safety Box, 5 Litre (Capacity 100 syringes)		-		89,161	-	
			-			-	
	Total SIAs Cost		-		815,904	-	
Grand Total for Syringes		922,596	1,028,053	1,017,565	1,947,513	1,260,847	17,814,399

Vaccine Forecast for the Year 2003-2010

	2003	2004	2005	2006	2007	2008	2009	2010
Yearly Population Projections								
Total Population	22,200,000	22,626,240	23,060,664	23,503,429	23,954,694	24,414,625	24,883,385	25,361,146
Under one (4% of population)	888,000	905,050	922,427	940,137	958,188	976,585	995,335	1,014,446
Under 5 (20% of population)	4,440,000	4,525,248	4,612,133	4,700,686	4,790,939	4,882,925	4,976,677	5,072,229
Pregnant Women (5% of population)	1,110,000	1,131,312	1,153,033	1,175,171	1,197,735	1,220,731	1,244,169	1,268,057
CBA Women (20% of population)	4,440,000	4,525,248	4,612,133	4,700,686	4,790,939	4,882,925	4,976,677	5,072,229
BCG Doses	1,332,000	1,357,574	1,383,640	1,410,206	1,437,282	1,464,877	1,493,003	1,521,669
DPT Doses	3,729,600	3,801,208	3,874,192	3,948,576	4,024,389	4,101,657	4,180,409	4,260,673
OPV For Routine	26,640,000	27,151,488	27,672,797	28,204,114				
OPV for NID/SNID	1,332,000	1,357,574	1,383,640	1,410,206	1,437,282	1,464,877	1,493,003	1,521,669
Measles For Routine	4,528,800			4,794,699				5,173,674
Measles For Campaign	3,108,000	3,167,674	3,228,493	3,290,480	3,353,657	3,418,047	3,483,674	3,550,560
TT For Routine(Preg. Only)	15,984,000	16,290,893						
TT For SIAs (100% of CBAs)	98,703	131,956	150,106	165,248	181,615	200,132	220,099	242,402
BCG Vaccine	399,114	527,912	602,204	664,150	732,922	808,847	892,266	983,534
DPT Vaccine	458,895	455,765	502,870	551,616	606,475	667,750	735,752	810,806
OPV For Routine	3,333,264	2,992,365	3,286,698	3,621,408	-	-	-	-
OPV for NID/SNID	217,129	182,458	192,437	212,208	234,306	257,174	282,536	310,512
Measles For Routine	1,034,981		-	765,234	-	-	-	1,209,088
Measles For Campaign	164,434	235,485	272,227	297,854	328,524	360,262	397,418	435,867
TT For Routine(Preg. Only)	130,471	536,622	-	-	-	-	-	-
TT For SIAs (100% of CBAs)	5,836,992	5,062,563	5,006,541	6,277,719	2,083,842	2,294,164	2,528,070	3,992,208
Total Cost Of Vaccines								

	2003	2004	2005	2006	2007	2008	2009	2010
Rec. Cost Total for EPI	8,120,310	7,542,043	5,762,092	7,605,556	3,018,641	3,219,427	3,557,032	5,894,823
Capital Costs		1,177,786	385,365	466,136	397,488	868,711	727,613	453,036
Grand Total		8,719,829	6,147,457	8,071,692	3,416,129	4,088,138	4,284,645	6,347,859

Vaccine Forecast for the Year 2011-2015							
		2011	2012	2013	2014	2015	Total
Yearly Population Projections	Total Population	25,848,080	26,344,363	26,850,175	27,365,699	27,891,120	
	Under one (4% of population)	1,033,923	1,053,775	1,074,007	1,094,628	1,115,645	
	Under 5 (20% of population)	5,169,616	5,268,873	5,370,035	5,473,140	5,578,224	
	Pregnant Women (5% of population)	1,292,404	1,317,218	1,342,509	1,368,285	1,394,556	
	CBA Women (20% of population)	5,169,616	5,268,873	5,370,035	5,473,140	5,578,224	
	BCG Doses	1,550,885	1,580,662	1,611,011	1,641,942	1,673,467	
Total doses of vaccines required for EPI programme	DPT Doses	4,342,477	4,425,853	4,510,829	4,597,437	4,685,708	
	OPV For Routine	4,342,477	4,425,853	4,510,829	4,597,437	4,685,708	
	OPV for NID/SNID						
	Measles For Routine	1,550,885	1,580,662	1,611,011	1,641,942	1,673,467	
	Measles For Campaign	5,273,008	5,374,250	5,477,436	5,582,603	5,689,788	
	TT For Routine(Preg. Only)	3,618,731	3,688,211	3,759,025	3,831,198	3,904,757	
	TT For SIAs (100% of CBAs)						
Cost of vaccines as per 2004 price including freight + 8% annual increase	BCG Vaccine	247,056	251,799	256,634	261,561	266,583	
	DPT Vaccine	1,002,418	1,021,664	1,041,280	1,061,272	1,081,649	
	OPV For Routine	826,373	842,240	858,411	874,892	891,690	
	OPV for NID/SNID	-	-	-	-	-	
	Measles For Routine	316,474	322,550	328,743	335,055	341,488	
	Measles For Campaign				1,304,654		
	TT For Routine(Preg. Only)	444,235	452,765	461,458	470,318	479,348	
	TT For SIAs (100% of CBAs)	-	-	-	-	-	
Total Cost Of Vaccines		2,836,556	2,891,018	2,946,525	4,307,753	3,060,758	49,124,709
Rec.Cost Total for EPI		2011	2012	2013	2014	2015	
		3,759,152	3,919,071	3,964,091	6,255,266	4,321,605	66,939,109
Capital Costs		440,338	584,586	529,613	653,461	628,138	7,312,269
Grand Total		4,199,489	4,503,657	4,493,703	6,908,727	4,949,743	74,251,377

(b) Malaria and Leishmaniasis

Dated: 17 Jan, 2

Malaria Control (Beyond BPHS) Costing Forecast 2004 -2010							
	Year	2004	2005	2006	2007	2008	2009
Target population	Total Population	22,626,240	23,060,664	23,503,429	23,954,694	24,414,625	24,883,385
	High Endemic 14 provinces population	7,851,917	8,002,674	8,156,325	8,312,926	8,472,535	8,635,207
	Rough estimation of malaria infection cases	2,700,000	2,430,000	2,187,000	1,968,300	1,771,470	1,594,323
	Estimated severe Plasmodium falciparum cases	540,000	486,000	437,400	393,660	354,294	318,865
Treatment sever/complicated P. falciparum cases with new regime	Malaria drugs (Artesunate/Fansidar)	162,000	174,960	209,952	188,957	170,061	191,319
	Provision of outbreak response contingency stocks	100,000	100,000	100,000	100,000	100,000	100,000
	Total Drugs for sever Malaria	262,000	274,960	309,952	288,957	270,061	291,319
Human resource development and training for Malaria treatment in high endemic areas	Training for doctors in 14 provinces	10,500	10,500	10,500	10,500	10,500	10,500
	Training for HP/BHC CHC staff in 14 provinces	42,000	42,000	42,000	42,000	42,000	42,000
	Master training for the integration with BPHS	18,000	18,000	18,000	18,000	18,000	18,000
	Total Training Costs for DOTS	70,500	70,500	70,500	70,500	70,500	70,500
Insecticide treated nets (ITNs), social marketing	Total distribution No. of ITNs for 14 provinces	296,779	373,381	380,550	378,059	385,317	392,716
	Procurement and targeted distributions of ITNs for widows	37,016	37,727	38,451	19,595	19,971	20,354
	Subsidies of ITNs for rural population in 14 provinces	252,920	322,221	328,407	334,713	341,139	347,689
	User contributions of ITNs distribution in rural areas of 14 provinces	252,920	322,221	328,407	334,713	341,139	347,689
	Social marketing/user charges of ITNs in urban areas of 14 provinces	50,701	64,593	65,833	67,097	68,385	69,698
Advocacy	Total ITNs for 14 provinces	593,558	746,761	761,099	756,117	770,635	785,431
	Community mobilization	30,000	30,000	30,000	30,000	30,000	30,000
Total for Malaria program iof Recurrent costs		956,058	1,122,221	1,171,551	1,145,574	1,141,196	1,177,250
	Grand Total for Malaria program	956,058	1,122,221	1,171,551	1,145,574	1,141,196	1,177,250
	Potential user charge	303,621	386,814	394,241	401,810	409,525	417,388

Dated: 17 Jan, 2004

Malaria Control (Beyond BPHS) Costing Forecast 2004 -2010		2011-2015					
Year		2011	2012	2013	2014	2015	Total 2003-2015
Target population	Total Population	25,848,080	26,344,363	26,850,175	27,365,699	27,891,120	
	High Endemic 14 provinces population	8,969,982	9,142,206	9,317,736	9,496,637	9,678,972	
	Rough estimation of malaria infection cases	1,291,402	1,162,261	1,046,035	941,432	847,289	
	Estimated severe Plasmodium falciparum cases	258,280	232,452	209,207	188,286	169,458	
Treatment sever/complicated P. falciparum cases with new regime	Malaria drugs (Artesunate/Fansidar)	R 185,962	167,366	175,734	158,161	162,679	
	Provision of outbreak response contingency stocks	R 100,000	100,000	100,000	100,000	100,000	
	Total Drugs for severe Malaria	285,962	267,366	275,734	258,161	262,679	3,319,337
Human resource development and training for Malaria treatment in high endemic areas	Training for doctors in 14 provinces	R 10,500	10,500	10,500	10,500	10,500	
	Training for HP/BHC CHC staff in 14 provinces	R 42,000	42,000	42,000	42,000	42,000	
	Master training for the integration with BPHS	R 18,000	18,000	18,000	18,000	18,000	
	Total Training Costs for DOTS	70,500	70,500	70,500	70,500	70,500	846,000
Insecticide treated nets (ITNs), social marketing	Total distribution No. of ITNs for 14 provinces	407,941	415,773	423,756	431,892	440,184	4,726,603
	Procurement and targeted distributions of ITNs for widows	R 21,144	21,549	21,963	22,385	22,815	
	Subsidies of ITNs for rural population in 14 provinces	R 361,169	368,103	375,171	382,374	389,715	
	User contributions of ITNs distribution in rural areas of 14 provinces	UC 361,169	368,103	375,171	382,374	389,715	
	Social marketing/user charges of ITNs in urban areas of 14 provinces	UC 72,401	73,791	75,207	76,651	78,123	
	Total ITNs for 14 provinces	815,881	831,546	847,512	863,784	880,369	9,453,206
Advocacy	Community mobilization	R 30,000	30,000	30,000	30,000	30,000	360,000
Total for Malaria program (of Recurrent costs)		1,202,343	1,199,412	1,223,746	1,222,445	1,243,548	18,705,145
Grand Total for Malaria program		1,202,343	1,199,412	1,223,746	1,222,445	1,243,548	18,705,145
Potential user charge		433,569	441,894	450,378	459,025	467,839	

(c) Public Nutrition

Public Nutrition Costing Forecast 2004 -2010								
	Year	2004	2005	2006	2007	2008	2009	2010
Target population	Total Population		22,626,240	23,060,664	23,503,429	24,414,625	24,883,385	25,361,146
	Under one (4% of population)		905,050	922,427	940,137	958,188	976,585	995,335
	Under 5 (20% of population)		4,525,248	4,612,133	4,700,686	4,790,939	4,882,925	4,976,677
	Pregnant Women (5% of population)		1,131,312	1,153,033	1,175,171	1,197,735	1,220,731	1,244,169
	CBA Women (20% of population)		4,525,248	4,612,133	4,700,686	4,790,939	4,882,925	4,976,677
Universal Salt Iodization	Monitoring and quality control	R	10,000	10,000	10,000	10,000	10,000	10,000
	Laboratory capacity and support (urine analysis)	R	10,000	10,500	11,025	11,576	12,155	12,763
	Establishing Laboratory	C	100,000					
	Communication, social marketing and advocacy	R	50,000	50,960	51,938	52,936	53,952	54,988
	Training, global networks, debates an advocacy	R	5,000	5,000	5,000	5,000	5,000	5,000
Fortification of wheat	Total Universal Salt Iodization		175,000	76,460	77,963	79,512	81,107	82,751
	Monitoring and quality control	R	10,000	10,000	10,000	10,000	10,000	10,000
	Laboratory capacity and support (blood and urine analysis)	R	10,000	15,000	22,500	33,750	50,625	75,938
	Communication, social marketing and advocacy	R						
	Training, global networks, debates an advocacy	R	5,000	5,000	5,000	5,000	5,000	5,000
Treatment of Severe Malnutrition	Total Fortification of wheat		25,000	30,000	37,500	48,750	65,625	90,938
	Support Training Center 10 TFUs in total	R	72,000	72,000	144,000	144,000	216,000	288,000
	Support for 50 District TFT centers in total	R	-	60,000	123,600	190,962	262,254	337,653
	Total Treatment of Severe Malnutrition		72,000	132,000	267,600	334,962	478,254	553,653
	Training and monitoring		8,000	8,000	8,000	8,000	8,000	8,000
Support for Baby Friendly Hospital Initiative	Total Support for Baby Friendly Hospital Initiative		8,000	8,000	8,000	8,000	8,000	8,000
	Implementation of Supplementation projects (three year projects, two times)	R	500,000	500,000	250,000	250,000		
	Annual Recurrent Cost Projections		680,000	746,460	641,063	721,224	632,987	727,341
		Annual Capital Costs Projections		100,000	-	-	-	-
	Grand Total for Public Nutrition			780,000	746,460	641,063	721,224	727,341

Public Nutrition Costing Forecast 2004 -2010		2011-2015					
	Year	2011	2012	2013	2014	2015	Total 2003-2015
Target population	Total Population	25,848,080	26,344,363	26,850,175	27,365,699	27,891,120	
	Under one (4% of population)	1,033,923	1,053,775	1,074,007	1,094,628	1,115,645	
	Under 5 (20% of population)	5,169,616	5,268,873	5,370,035	5,473,140	5,578,224	
	Pregnant Women (5% of population)	1,292,404	1,317,218	1,342,509	1,368,285	1,394,556	
	CBA Women (20% of population)	5,169,616	5,268,873	5,370,035	5,473,140	5,578,224	
	Monitoring and quality control	R 10,000	10,000	10,000	10,000	10,000	
Universal Salt Iodization	Laboratory capacity and support (urine analysis)	R 14,071	14,775	15,513	16,289	17,103	
	Establishing Laboratory	C					
	Communication, social marketing and advocacy	R 57,120	58,216	59,334	60,473	61,634	
	Training, global networks, debates an advocacy	R 5,000	5,000	5,000	5,000	5,000	
	Total Universal Salt Iodization	86,191	87,991	89,847	91,762	93,738	1,106,767
	Monitoring and quality control	R 10,000	10,000	10,000	10,000	10,000	
Fortification of wheat	Laboratory capacity and support (blood and urine analysis)	R 170,859	256,289	384,434	576,650	864,976	
	Communication, social marketing and advocacy	R					
	Training, global networks, debates an advocacy	R 5,000	5,000	5,000	5,000	5,000	
	Total Fortification of wheat	185,859	271,289	399,434	591,650	879,976	2,754,927
	Support Training Center 10 TFUs in total	R 288,000	360,000	360,000	370,800	381,924	
	Support for 50 District TFT centers in total	R 501,502	590,339	540,000	600,000	600,000	
Treatment of Severe Malnutrition	Total Treatment of Severe Malnutrition	789,502	950,339	900,000	970,800	981,924	7,136,373
	Training and monitoring	8,000	8,000	8,000	8,000	8,000	
Support for Baby Friendly Hospital Initiative	Total Support for Baby Friendly Hospital Initiative	8,000	8,000	8,000	8,000	8,000	88,000
Large scale pilot project for Micronutrients Supplementation	Implementation of Supplementation projects (three year projects, two times)						1,000,000
Annual Recurrent Cost Projections		1,069,552	1,317,619	1,397,281	1,662,213	1,963,637	
Annual Capital Costs Projections		-	-	-	-	-	
Grand Total for Public Nutrition		1,069,552	1,317,619	1,397,281	1,662,213	1,963,637	12,086,067

(d). Tuberculosis

Tuberculosis Control (Beyond BPHS) Costing Forecast 2004 -2010									
	Year								
		2004	2005	2006	2007	2008	2009		
Target population	Total Population	22,626,240	23,060,664	23,503,429	23,954,694	24,414,625	24,883,385		
	No. of New TB cases detected	40,000	54,000	60,000	65,000	68,000	66,000		
	New detections per 100,000 population	177	234	255	271	279	265		
	No. of health facilities diagnosing TB	263	341	400	450	500	550		
DOTS implementation	No. of health facilities offering DOTS	490	739	850	900	950	1,000		
	TB drugs	560,000	756,000	840,000	910,000	952,000	924,000		
	DOTS shelters for TB patients	50,000	50,000	50,000	50,000	50,000	50,000		
	Operation costs for DOTS shelter	21,000	42,000	63,000	84,000	105,000	126,000		
Training for DOTS	Total DOTS implementation	631,000	848,000	953,000	1,044,000	1,107,000	1,100,000		
	Laboratory microscopy training*4	11,850	11,700	8,850	7,500	7,500	7,500		
	Medical doctor training for DOTS*5	16,640	19,920	8,880	4,000	4,000	4,000		
	Health worker training for DOTS*6	20,800	24,900	11,100	5,000	5,628	5,796		
Laboratory equipment	Community health worker training for DOTS*7	12,480	15,388	7,066	3,000	3,000	3,000		
	Refresh / new employee courses for DOTS*8	80,000	80,000	80,000	80,000	80,000	80,000		
	Total Training Costs for DOTS	141,770	151,908	115,896	99,500	100,128	100,296		
	Microscopy	197,500	195,000	147,500	125,000	125,000	125,000		
National Reference Laboratory	Spear parts	32,875	42,625	50,000	56,250	62,500	68,750		
	Total Laboratory equipment	230,375	237,625	197,500	181,250	187,500	193,750		
	Operation costs	50,000	50,000	50,000	50,000	50,000	50,000		
	Total National Reference Laboratory	50,000	50,000	50,000	50,000	50,000	50,000		
Regional Reference Laboratory	Operation costs	50,000	50,000	75,000	100,000	125,000	150,000		
	Total National Reference Laboratory	50,000	50,000	75,000	100,000	125,000	150,000		
	Community mobilization	30,000	30,000	30,000	30,000	30,000	30,000		
	Total for Tuberculosis program including Cap. + Rec	1,133,145	1,367,533	1,421,396	1,504,750	1,599,628	1,624,046		
Summary of TB control		2004	2005	2006	2007	2008	2009		
Capital Cost total		247,500	245,000	197,500	175,000	175,000	175,000		
Annual Recurrent cosr total		885,645	1,122,533	1,223,896	1,329,750	1,424,628	1,449,046		
Grand Total		1,133,145	1,367,533	1,421,396	1,504,750	1,599,628	1,624,046		

Tuberculosis Control (Beyond BPHS) Costing Forecast 2004 - 2010		2011-2015						Total 2003-2015
	Year	2011	2012	2013	2014	2015		
Target population	Total Population	25,848,080	26,344,363	26,850,175	27,365,699	27,891,120		
	No. of New TB cases detected	60,000	55,000	50,000	45,000	40,000		
	New detections per 100,000 population	232	209	186	164	143		
	No. of health facilities diagnosing TB	650	650	650	650	650		
	No. of health facilities offering DOTS	1,100	1,200	1,250	1,300	1,350		
DOTS implementation	TB drugs	840,000	770,000	700,000	630,000	560,000		
	DOTS shelters for TB patients							
	Operation costs for DOTS shelter	134,400	134,400	134,400	134,400	134,400		
	Total DOTS implementation	974,400	904,400	834,400	764,400	694,400		10,919,400
	Laboratory microscopy training*4	7,500	-	-	-	-		
Training for DOTS	Medical doctor training for DOTS*5	4,000	-	-	-	-		
	Health worker training for DOTS*6	6,149	12,299					
	Community health worker training for DOTS*7	3,000	6,000	6,000	6,000	6,000		
	Refresh / new employee courses for DOTS*8	80,000	80,000	80,000	80,000	80,000		
	Total Training Costs for DOTS	100,649	98,299	86,000	86,000	86,000		1,266,916
Laboratory equipment	Microscopy	322,500	195,000	147,500	125,000	125,000		2,415,000
	Spear parts	81,250	81,250	81,250	81,250	81,250		794,250
	Total Laboratory equipment	403,750	276,250	228,750	206,250	206,250		3,209,250
	Operation costs	50,000	50,000	50,000	50,000	50,000		
	Total National Reference Laboratory	50,000	50,000	50,000	50,000	50,000		600,000
Regional Reference Laboratory	Operation costs	200,000	225,000	225,000	225,000	225,000		
	Total National Reference Laboratory	200,000	225,000	225,000	225,000	225,000		1,825,000
	Community mobilization	30,000	30,000	30,000	30,000	30,000		
	Total National Reference Laboratory	30,000	30,000	30,000	30,000	30,000		360,000
	Total for Tuberculosis program including Cap. + Rec	1,758,799	1,583,949	1,454,150	1,361,650	1,291,650		18,180,566
Summary of TB control		2011	2012	2013	2014	2015		
Capital Cost total		322,500	195,000	147,500	125,000	125,000		
Annual Recurrent cosr total		1,436,299	1,388,949	1,306,650	1,236,650	1,166,650		
Grand Total		1,758,799	1,583,949	1,454,150	1,361,650	1,291,650		

(e). Emergency Preparedness and Response

Emergency Response and Preparedness Costing Forecast 2004 -2010									
Target population	Year			2004	2005	2006	2007	2008	2009
	Total Population			22,626,240	23,060,664	23,503,429	23,954,694	24,414,625	24,883,385
Contingency for Emergency Outbreak Responses	Drugs/Vaccines	R		250,000	254,800	259,692	264,678	269,760	274,939
	Field operation fees	R		90,000	91,728	93,489	95,284	97,114	98,978
	Other small scale operations	R		30,000	30,576	30,001	30,577	30,002	30,578
	Total Contingency for Emergency Outbreak Response			370,000	377,104	383,182	390,539	396,876	404,496
	Human resource costs	R		40,920	40,920	40,920	40,920	40,920	40,920
National Reference Laboratory (for confirmation)	Operation costs for Reference laboratory services	R		36,000	36,000	36,000	36,000	36,000	36,000
	Diagnostic equipemnt provision with spare parts	C		110,000	10,000	10,000	10,000	10,000	127,520
	Refresh Training for MDs and Laboratory Technicians	R		1,180	1,180	1,180	1,180	1,180	1,180
	Total National Reference Labo			188,100	88,100	88,100	88,100	88,100	205,620
	Human resource cost	R		33,600	33,600	33,600	33,600	33,600	33,600
Provincial Reference Laboratories (five cities)	Operation costs for Reference laboratory services	R		18,000	18,000	18,000	18,000	18,000	18,000
	Diagnostic equipemnt provision with spare parts	C		13,750	1,250	1,250	1,250	1,250	15,940
	Reresh Training for MDs and Laboratory Technicians	R		1,000	1,000	1,000	1,000	1,000	1,000
	Total Regional Reference Labo			66,350	53,850	53,850	53,850	53,850	68,540
	Master training			12,000	12,000	12,000	12,000	12,000	12,000
Community Based Emaergency Preparedness Response	Community based training	R		8,640	8,806	8,975	9,147	9,323	9,502
	First aid kits	R		15,180	15,471	15,769	16,071	16,380	16,694
	Materials	R		7,500	7,644	7,791	7,940	8,093	8,248
	Totlia Early Community Response			31,320	31,921	32,534	33,159	33,796	34,444
	Natioanl Advocacy	R		20,000	20,000	20,000	20,000	20,000	20,000
Advocay and IEC	Total Advocacy			20,000	20,000	20,000	20,000	20,000	20,000
Emergency Hospital in Kabul	Rehabilitation Reinforcement of Building for Emergency Preparedness and mitigation		C	300,000					
	Emergency recurrent costs			552,020	559,725	566,417	574,398	581,371	589,640
	Emergency capital costs			423,750	11,250	11,250	11,250	11,250	143,460
	Grand total			975,770	570,975	577,667	585,648	592,621	733,100

Dated: 18.01.2004

Emergency Response and Preparedness Costing Forecast 2004 -2010		2011-2015 Forecast							Total 2003-2015
Target population	Year	2011	2012	2013	2014	2015			
Total Population		25,848,080	26,344,363	26,850,175	27,365,699	27,891,120			
Drugs/Vaccines	R	285,598	291,082	299,814	308,809	318,073			
Field operation fees	R	102,815	104,790	106,801	108,852	110,942			
Other small scale operations	R	30,579	30,004	30,580	30,005	30,581			
Total Contingency for Emergency Outbreak Response		418,993	425,876	437,196	447,666	459,596			
Human resource costs	R	40,920	40,920	40,920	40,920	40,920			
Operation costs for Reference laboratory services	R	36,000	36,000	36,000	36,000	36,000			
Diagnostic equipment provision with spare parts	C	10,000	10,000	10,000	147,831	13,842			
Refresh Training for MDs and Laboratory Technicians	R	1,180	1,180	1,180	1,180	1,180			
Total National Reference Labo		88,100	88,100	88,100	225,931	91,942			
Human resource cost	R	33,600	33,600	33,600	33,600	33,600			
Operation costs for Reference laboratory services	R	18,000	18,000	18,000	18,000	18,000			
Diagnostic equipment provision with spare parts	C	1,594	1,594	1,594	21,422	2,142			
Refresh Training for MDs and Laboratory Technicians	R	1,000	1,000	1,000	1,000	1,000			
Total Regional Reference Labo		54,194	54,194	54,194	74,022	54,742			
Master training		12,000	12,000	12,000	12,000	12,000			
Community based training	R	9,870	10,060	10,253	10,450	10,650			
First aid kits	R	17,342	17,674	18,014	18,360	18,712			
Materials	R	8,568	8,732	8,900	9,071	9,245			
Total Early Community Response		35,780	36,467	37,167	37,881	38,608			
National Advocacy	R	20,000	20,000	20,000	20,000	20,000			
Total Advocacy		20,000	20,000	20,000	20,000	20,000			
Rehabilitation Reinforcement of Building for Emergency	C								
Preparedness and mitigation		605,473	613,042	625,063	636,246	648,904			
Emergency recurrent costs									
Emergency capital costs		11,594	11,594	11,594	169,253	15,985			
Grand total		617,067	624,636	636,657	805,499	664,889			

(f). HIV/AIDS

STH/VIAIDS Costing Forecast 2004 - 2010										
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Target population	Total population	27,025,240	27,025,240	27,025,240	27,025,240	27,025,240	27,025,240	27,025,240	27,025,240	27,025,240
	Population 15-35 years	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
	Population 15-35 years	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
	Population 15-35 years	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
National Surveillance System	Establishing National Surveillance System	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
	Establishing National Surveillance System	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
	Establishing National Surveillance System	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
	Establishing National Surveillance System	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
Establishing safe blood supply system	Establishing safe blood supply system	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
	Establishing safe blood supply system	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
	Establishing safe blood supply system	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
	Establishing safe blood supply system	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
Condom social marketing	Condom free distribution	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
	Condom free distribution	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
	Condom free distribution	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
	Condom free distribution	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
VCT Center	Total No of VCT center	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
	Total No of VCT center	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
	Total No of VCT center	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
	Total No of VCT center	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
BCC interventions to high risk group	BCC interventions to high risk group	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
	BCC interventions to high risk group	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
	BCC interventions to high risk group	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
	BCC interventions to high risk group	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
Advocacy and IEC	Advocacy and IEC	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
	Advocacy and IEC	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
	Advocacy and IEC	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
	Advocacy and IEC	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
STDA/VIAIDS treatment, care and support	STDA/VIAIDS treatment, care and support	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
	STDA/VIAIDS treatment, care and support	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
	STDA/VIAIDS treatment, care and support	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
	STDA/VIAIDS treatment, care and support	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000	11,000,000
STH/VIAIDS control program										
Annual Recurrent Cost Projections										
Annual Capital Cost Projections										
Grand total										
Potential user contribution										

Dated: Jan 15, 2004

STH/VHADS Costing Forecast 2004-2010		2011-2015 Forecast						Total 2003-2015
Target population	Year	2011	2012	2013	2014	2015		
		25,848,080	26,344,363	26,850,175	27,356,899	27,863,720		
Total population	Living pop 15 years +	25,848,080	26,344,363	26,850,175	27,356,899	27,863,720		
	Living pop 15 years + Blood transfusion	2,618,813	2,653,813	2,688,813	2,723,813	2,758,813		
	No. of Facilities available safe blood for STH/VH/BH/CV	84,872	86,008	87,120	88,256	89,375		
	No. of Sentinel facility	195	180	165	210	215		
National Surveillance System								
Establishing National Surveillance System	R	410,000	410,000	410,000	410,000	410,000		
	Total National Surveillance system	410,000	410,000	410,000	410,000	410,000		4,550,000
	Equipment with spare parts for safe blood trans fusion	4,400	4,400	4,400	4,400	4,400		
	Equipment with spare parts for safe blood trans fusion	34,540	34,540	34,540	34,540	34,540		
Establishing safe blood supply system	HIV Rapid Test	84,872	85,008	85,120	85,256	85,375		
	HIV ELISA kits	18,000	18,000	18,000	18,000	18,000		
	HBsAg kits	50,271	50,271	50,271	50,271	50,271		
	HBsAg kits	42,338	42,338	42,338	42,338	42,338		
Total Safe Blood Supply	R	642,639	677,132	688,899	722,485	748,831		7,105,819
	Condom free distribution	131,825	134,356	136,938	139,522	142,104		
	Potential user contribution	23,283	23,719	24,165	24,612	25,058		
	Total Condom Social Marketing	155,088	158,066	161,091	164,081	167,162		1,782,280
VCT Center	Total No of VCT center	34	36	38	40	40		
	Initial training for VCT center staff	6,000	6,000	6,000	6,000	6,000		120,000
	Refresh training for VCT center staff	150,000	164,000	220,000	258,000	298,000		1,399,000
	Human resource cost	211,200	220,800	230,400	240,000	240,000		1,987,200
Total VCT center	R	105,580	105,740	107,620	108,900	108,900		1,177,740
	Test kit and IEC material	422,860	517,540	564,220	612,500	645,900		4,883,940
BCC interventions to high risk group	Estimated number of High Risk Group	459,474	465,564	478,037	487,598	497,350		
	IECC interventions for high risk groups	1,033,817	1,054,493	1,075,583	1,097,095	1,119,037		8,686,233
	Total BCC interventions	1,633,817	1,654,493	1,675,583	1,697,095	1,719,037		6,133,107
Advocacy and IEC	Nalacat Advocacy	50,000	50,000	50,000	50,000	50,000		
	IE/Cills saving kit training against HIV/Drg abuse for young	620,354	632,265	644,404	727,454	738,328		7,199,555
	Total BCC interventions	670,354	682,265	694,404	777,454	788,328		7,220,828
	STD treatment	20,000	20,000	20,000	20,000	20,000		240,000
STH/VHADS treatment, care and support	HIV/AIDS treatment and care	80,400	87,600	94,800	102,000	109,200		837,600
	PWAs supports by Peer group, NGOs and communities	200,000	200,000	250,000	250,000	250,000		1,750,000
	Total STH/VHADS treatment/care/support	300,400	307,600	344,800	372,000	379,200		2,827,600
STH/VHADS control program	Annual Recurrent Cost Projections	3,655,158	3,807,097	3,959,018	4,107,548	4,274,375		60,151,640
	Annual Capital Cost Projections	46,400	46,400	46,400	46,400	46,400		38,911,422
	Grand total	3,655,158	3,807,097	3,959,018	4,107,548	4,274,375		37,193,102
	Potential user contribution	23,283	23,719	24,165	24,612	25,058		206,076

3. Improving Quality of Hospital Services

Total Secondary and Tertiary Hospital beds in Afghanistan 2004-2015

	2004/1383	2005/1384	2006/1385	2010/1389	2015/1394
Total Provincial Hospital beds operational in the Provinces	1700	1700	1900	2500	2700
Total Regional Hospital beds operational in the Provinces	1600	1600	1800	1600	1600
Total Provincial Hospital beds operational in Kabul	1400	1400	1400	1400	1400
Total Regional Hospital beds operational in Kabul	1200	1200	1200	1200	1200
Total Tertiary Hospital beds operational in Kabul	400	400	400	400	400
Cost per Provincial Hospital type bed per year (rehab)	\$4,281				
Cost per Provincial Hospital type bed per year (construction)	\$5,739				
Cost per Regional Hospital type bed per year	\$3,918				
Cost Tertiary Hospital bed per year	\$5,519				

Costs involved in the Construction and Equipping Health Clinics and Provincial and District Hospitals

Facility Type	Construction							
	Year 1 2004	Year 2 2005	Year 3 2006	Year 8 2011	Year 9 2012	Year 10 2013	Year 11 2014	Year 12 2015
CHC	50	50	25	25	25	25	25	0
BHC	100	100	75	50	50	50	50	0
District Hospital			5	5	5			0
Provincial Hospital			2					0
Subtotal	\$17,250,000	\$17,250,000	\$10,875,000	\$8,625,000	\$8,625,000	\$8,625,000	\$8,625,000	0
Subtotal cost CHC			\$20,625,000	\$4,125,000	\$4,125,000	\$4,125,000	\$4,125,000	\$16,500,000
Subtotal cost BHC			\$24,750,000	\$4,500,000	\$4,500,000	\$4,500,000	\$4,500,000	\$18,000,000
Subtotal cost District Hospital			\$5,750,000					\$11,500,000
Subtotal cost Provincial Hospital			\$3,433,710					
Total cost health facility			\$54,558,710					\$46,000,000

Example of the costing for a Regional

Regional Hospital Costing (200 beds)

Item	Qty	Unit Cost (\$)	Months	Total Cost (\$)	Capital Cost Yr (\$)	Recurrent Cost Yr (\$)
Staff						
Hospital Director	1	\$300	12	\$3,600		\$3,600
Hospital Administrator	1	\$150	12	\$1,800		\$1,800
(m) Head Nurse	1	\$140	12	\$1,680		\$1,680
(m) General Surgeon	2	\$350	12	\$8,400		\$8,400
(f) General Surgeon	1	\$500	12	\$6,000		\$6,000
Orthopedic Surgeon	1	\$400	12	\$4,800		\$4,800
Neuro Surgeon	1	\$400	12	\$4,800		\$4,800
Ophthalmologist	1	\$400	12	\$4,800		\$4,800
(m) General Doctor	18	\$170	12	\$36,720		\$36,720
(f) General Doctor	10	\$170	12	\$20,400		\$20,400
Internal Medicine Specialist	2	\$200	12	\$4,800		\$4,800
Pediatrician	1	\$200	12	\$2,400		\$2,400
Psychiatrist	1	\$200	12	\$2,400		\$2,400
Nutritionist	2	\$145	12	\$3,480		\$3,480
Hospital Hygienist	2	\$135	12	\$3,240		\$3,240
Nurse	85	\$120	12	\$99,600		\$99,600
Nurse-midwife	19	\$140	12	\$31,920		\$31,920
Anesthetist	1	\$200	12	\$2,400		\$2,400
Anesthetist assistant	5	\$125	12	\$6,540		\$6,540
Physiotherapist	3	\$145	12	\$5,220		\$5,220
Pharmacist	1	\$180	12	\$1,920		\$1,920
Pharmacy assistant	5	\$125	12	\$7,500		\$7,500
X-ray technician	4	\$150	12	\$7,200		\$7,200
Laboratory technician	5	\$110	12	\$7,920		\$7,920
EPI vaccinator	5	\$90	12	\$5,760		\$5,760
Clark	4	\$100	12	\$4,800		\$4,800
cleaner	12	\$60	12	\$8,640		\$8,640
guard	5	\$55	12	\$3,960		\$3,960
cook	2	\$55	12	\$1,560		\$1,560
laundry man or woman	4	\$50	12	\$2,880		\$2,880
driver	3	\$50	12	\$3,240		\$3,240
Total Staff	192					
Total Medical Staff	160					
Total Support Staff	27					
Total Administrative Staff	5					
Drugs and Medical Supplies						
Supply of Drugs and Medical Supplies	1	\$12,000	12	\$144,000		\$144,000
Medical Equipment						
X-ray machine	1	\$50,000	1	\$50,000	\$10,917.76	
Portable Ultrasound Machine	1	\$7,500	1	\$7,500	\$1,638	
Theater Table	3	\$3,000	1	\$9,000	\$1,995	
Theater Lamp	3	\$500	1	\$1,500	\$328	
Steamsterilizer	2	\$1,000	1	\$2,000	\$437	
Oxygenator	3	\$3,500	1	\$10,500	\$2,293	
Suction machine electrical	3	\$250	1	\$750	\$164	
Generator	2	\$10,000	1	\$20,000	\$4,367	
Van Harnel Neonatal Incubator	4	\$400	1	\$1,600	\$349	
Delivery Room Beds	5	\$2,000	1	\$12,000	\$2,520	
Orthopedic Bed	10	\$500	1	\$5,000	\$1,092	
Hospital beds	190	\$150	1	\$28,500	\$6,223	
Bed side lockers	200	\$50	1	\$10,000	\$2,184	
Laboratory equipment	1	\$40,000	1	\$40,000	\$8,734	
Miscellaneous medical equipment	1	\$10,000	1	\$10,000	\$2,184	
Furniture and office equipment						
Solar Panels etc	2	\$5,000	1	\$10,000	\$2,184	
Desktop computer and accessories	1	\$1,000	1	\$1,000	\$522.80	
Office furniture	1	\$1,500	1	\$1,500	\$327.53	
Hospital furniture (local produce)	1	\$4,000	1	\$4,000	\$2,080.41	
Other Recurrent						
cleaning material	1	\$300	12	\$3,600		\$3,600
office expenditure	1	\$100	12	\$1,200		\$1,200
food for inpatients and staff	1	\$6,100	12	\$73,200		\$73,200
fuel and maintenance generator	1	\$1,057	12	\$12,684		\$12,684
small maintenance	1	\$250	12	\$3,000		\$3,000
fuel for kitchen and for heating	1	\$1,830	12	\$21,960		\$21,960
Capital						
Ambulance	2	\$30,000			\$13,101	
Rehabilitation	1	\$500,000			\$33,809	
Subtotals without contingency				\$1,351,094	197,327	\$584,244
Contingency						
Add contingency				\$14,18,649	\$102,194	\$584,556
Subtotal for the first year including rehab.				\$1,418,649		
Subtotal capital cost after the first year					\$102,194	
Subtotal recurrent cost after the first year						\$584,556
Subtotal operating cost after the first year				\$696,750		
Income						
Income (10% of recurrent budget)						\$17,837
Grand total operating cost after the first year				\$678,913		
Cost per bed per year after the first year				\$3,395		

4. Human Resource Development

Staff Kabul IHS					
	QTY	Unit Cost/month	months	cost/year	
Mamur (simple staff)	10	\$300	12	\$36,000	
Faculty	40	\$500	12	\$240,000	
Worker	20	\$130	12	\$31,200	
Total	70			\$307,200	
Staff Provincial IHS					
	QTY	Unit Cost/month	months	cost/year	
Mamur (simple staff)	5	\$300	12	\$18,000	
Faculty	20	\$500	12	\$120,000	
Worker	10	\$130	12	\$15,600	
Total for one provincial IHS	35			\$153,600	
Total for eight provincial IHSs				\$1,228,800	
Recurrent cost Kabul					
	QTY	Unit Cost/month	months	cost/year	
Maintenance	1	\$300	12	\$3,600	
Electricity/heating	1	\$1,000	12	\$12,000	
Communication	1	\$500	12	\$6,000	
Transport	1	\$4,000	12	\$48,000	
Accommodation long courses	360	\$250	12	\$1,080,000	
Accommodation short courses	600	\$100	12	\$720,000	
Teaching materials	960	\$10	12	\$115,200	
Total				\$1,984,800	
Recurrent cost Provincial IHS					
	QTY	Unit Cost/month	months	cost/year	
Maintenance	1	\$150	12	\$1,800	
Electricity/heating	1	\$500	12	\$6,000	
Fuel and maintenance	1	\$500	12	\$6,000	
Communication	1	\$600	12	\$7,200	
Transport	1	\$2,000	12	\$24,000	
Accommodation long courses	180	\$250	12	\$540,000	
Accommodation short courses	300	\$100	12	\$360,000	
Teaching materials	480	\$10	12	\$57,600	
Total for one provincial IHS				\$945,000	
Total for eight provincial IHSs				\$7,560,000	
Capital cost Kabul IHS					
	QTY	Unit Cost	months	cost 1st year	Cost after 1st year
Computers and accessories	20	\$1,000	1	\$20,000	\$10,452
Furniture	600	\$200	1	\$120,000	\$26,203
Library	1	\$10,000	1	\$10,000	\$1,000
Total				\$150,000	\$37,655
Capital cost Provincial IHS					
	QTY	Unit Cost	months	cost 1st year	Cost after 1st year
Computers and accessories	10	\$1,000	1	\$10,000	\$5,226
Furniture	300	\$200	1	\$60,000	\$13,101
Library	1	\$5,000	1	\$5,000	\$500
Internet connection	1	\$8,000	1	\$8,000	\$1,747
Solar panels for computers	5	\$2,000	1	\$10,000	\$2,184
Generator	1	\$10,000	1	\$10,000	\$5,226
Total for one provincial IHS				\$75,000	\$27,984
Total for eight provincial IHSs				\$600,000	\$223,870

5. Administrative Reform and Capacity Building

Total Number of Professional Staff put on PRR and 'Super Scale' Allowance for the Provincial Health Department

Post	Qty	Pay per month	Total (Af\$ month)	Type of Scale
Director of the Provincial Health Liaison Office	1	29,760	29,760	Superscale Level 1 Step 4
Chief Provincial Advisor	1	26,160	26,160	Superscale Level 1 Step 1
Senior Provincial Advisor	4	23,760	95,040	Superscale Level 2 Step 3
Administrator of the Provincial Health Liaison Office	1	8,225	8,225	Interim Additional Allowance Scheme Level C Step 1
Admin Officer of the Provincial Health Liaison Office	1	6,815	6,815	Interim Additional Allowance Scheme Level D Step 1
Clerk of the Provincial Health Liaison Office	1	6,815	6,815	Interim Additional Allowance Scheme Level D Step 1
Provincial Health Director	32	22,560	721,920	Superscale Level 2 Step 2
Administrator of the Provincial Health Office	32	8,225	263,200	Interim Additional Allowance Scheme Level C Step 1
Provincial RH and SMI Officer	32	21,360	683,520	Superscale Level 2 Step
Provincial Health Officer	192	11,045	2,120,640	Interim Additional Allowance Scheme Level A Step 1
Totals	297		3,962,095	
Average Pay per staff member per month			13,340	
Total number of Support Staff in new organogram	324	U		Interim Additional Allowance Scheme Level U (grades 4-6)
Ratio Professional to Support Staff		0.92		

Interim Additional Allowance Scale

Salary in Afghanis (1US\$ = 48 Af\$)

Post level	Steps			
	1	2	3	4
A	11,045	11,280	11,515	11,750
B	9,635	9,836	10,037	10,240
C	8,225	8,460	8,695	8,930
D	6,815	7,050	7,285	7,520
E	5,405	5,640	5,875	6,110
F	3,995	4,230	4,465	4,700
U	Unchange (Existing salary and allowances)			

Super Scale Allowance

Post Level	Steps			
	1	2	3	4
1	26,160	27,360	28,560	29,760
2	21,360	22,560	23,760	24,960
3	16,560	17,760	18,960	20,160
4	11,760	12,960	14,160	15,360

Technical assistance needs, per year

Advisors to MoH	CURRENT					
	International Advisors			Local Advisors		
	Current	Current	Current	Current	Current	Current
Office/Function	FT	PT	FTE	FT	PT	FTE
Policy & Planning						
GCMU	3	0	3	Unknown		
GD P&P	1	0	1			
Health Financing	1	0.5	1.5			
HMS	1	0.5	1.5			
External Coordination	0	0	0			
Human Resources	1	0.5	1.5			
Human Resources Development	0	0	0			
Health Care & Promotion						
Nutrition	2		2			
Safe Motherhood	1		1			
EPI	1		1			
NTP	3		3			
Malalai Hospital	2		2			
IEC	2		2			
Malaria	1		1			
IMCI	1		1			
Essential drugs		0.5	0.5			
Drug Quality Assurance	0	0	0			
Emergency preparedness	1		1			
Blood bank	2		2			
Hospital Management		0.5	0.5			
HIV/AIDS	1		1			
TB						
Management & Administration						
Construction	1		1			
Management	1		1			
Central Workshop	1		1			
Financial Management	0.5		0.5			
Provincial Health						
GD Provincial Health	1		1			
Additional areas						
Mental Health	0		0			
Environmental Health	0		0			
Global Fund			0			
Forensic Medicine			0			
Disability			0			

Technical assistance needs, per year

Advisors to MoH	PROJECTED		ESTIMATED COSTS		
	INT	LOCAL	INT	LOCAL	TOTAL
Office/Function					
Policy & Planning					
GCMU	3	4	900,000	96,000	996,000
GD P&P	1	2	300,000	48,000	348,000
Health Financing	2	2	600,000	48,000	648,000
HMIS	2	2	600,000	48,000	648,000
External Coordination	1	2	300,000	48,000	348,000
Human Resources	2	2	600,000	48,000	648,000
Human Resources Development	1	2	300,000	48,000	348,000
Health Care & Promotion					
Nutrition	2	2	600,000	48,000	648,000
Safe Motherhood	1	2	300,000	48,000	348,000
EPI	1	2	300,000	48,000	348,000
NTP	3	4	900,000	96,000	996,000
Malalai Hospital	2	3	600,000	72,000	672,000
IEC	2	3	600,000	72,000	672,000
Malaria	1	2	300,000	48,000	348,000
IMCI	1	2	300,000	48,000	348,000
Essential drugs	1	2	300,000	48,000	348,000
Drug Quality Assurance	1	2	300,000	48,000	348,000
Emergency preparedness	1	0	300,000	-	300,000
Blood bank	2	2	600,000	48,000	648,000
Hospital Management	1	2	300,000	48,000	348,000
HIV/AIDS	1	2	300,000	48,000	348,000
TB	2	2	600,000	48,000	648,000
Management & Administration					
Construction	1	2	300,000	48,000	348,000
Management	1	2	300,000	48,000	348,000
Central Workshop	1	2	300,000	48,000	348,000
Financial Management	1	2	300,000	48,000	348,000
Provincial Health					
GD Provincial Health	1	2	300,000	48,000	348,000
Additional areas					
Mental Health	1	2	300,000	48,000	348,000
Environmental Health	1	2	300,000	48,000	348,000
Global Fund	1	2	300,000	48,000	348,000
Forensic Medicine	1	2	300,000	48,000	348,000
Disability	1	2	300,000	48,000	348,000
	44	68	13,200,000	1,632,000	14,832,000

Estimating annual technical assistance needs
Draft of 20 December 2003

Categories	Number	Average Unit Cost	Total	Notes & assumptions
Human resources/personnel (advisors) for MOH	NA		\$4,832,000	see "MOH advisors" sheet
In-country training, workshops, and meetings for MOH				
Workshops	88	\$5,000	\$440,000	2 workshops per intl advisor per year
Training events	88	\$3,000	\$264,000	2 training events per intl advisor per year
Total			\$704,000	
Overseas conferences, meetings, and training for MOH				
Overseas conferences/meetings	96	\$5,350	\$513,600	8 overseas meetings per month
Overseas training	24	\$10,000	\$240,000	2 overseas trainings per month
Total			\$753,600	
Equipment and capital expenses for MOH				
Vehicles	8.8	\$10,000	\$88,000	one vehicle per 5 intl advisors, annual cost, assuming 5 yr depreciation
Computers & IT equipment	112	\$3,000	\$336,000	one computer per advisor (intl/local), +1000 per year Internet, other IT
Total			\$424,000	
NGO technical assistance costs per year			\$2,000,000	see "NGO TA costs" sheet
TOTAL			\$18,713,600	

Annex 4 List of Ongoing and Ready Projects

	<i>Sub program*1</i>	<i>Project Names</i>	<i>Status*2</i>	<i>Government DAD project No.</i>	<i>Main Donors</i>	<i>Implementing Partners</i>	<i>1382 Com. In M. US\$</i>	<i>1383 Req. In M.US\$</i>
1	BPHS	Afghanistan Health Sector Emergency Reconstruction and Development Project	O	AFG/03421 and AFG/03600	WB	COOPI, CHA, IbnSina, BRAC	59.6MUS\$ grant for three years	
2	BPHS		O	AFG/03421 and AFG/03600	EC	SCA, IbnSina, AHDS, ACF, AMI, HNI	25MEuro was earmarked	
3	BPHS	Rural Expansion of Afghanistan Community-Based Health Care (Reach)	O	AFG/03421 and AFG/03600	USAID	AKDN, IMC, BDF, CHA	100MUS\$ contract for three years	
4	BPHS	Primary health care partnership for the poor	O	AFG/03421 and AFG/03600	ADB	IbnSina NGO trustee	3MUS\$ grant for 30 months	
5	BPHS	Basic Health Services for Badghis	O	AFG/03908	KfW	Maltezer	3MEuro for three years	
6	BPHS	Rehabilitation of Economic Facilities and Service program	O	N.A.	USAID		*Construction started in 6 provinces	*About 400 clinics will be constructed
7	BPHS	Equipment provision to BPHS facilities	P	N.A.	JPN, WB			
8	SHP	Expanded Programme on Immunization	O	AFG/03421	CAN, CDCP, DNK, FIN, IDRC, JPN, USA, USAIDJ	UNICEF, SCF/US	19.623	20.3
9	SHP	Emergency Nutrition	O	AFG/03442	JPN, UK-DIFID, UNICEF	UNICEF	2.194	6.5
10	SHP	Caring Practice	O	AFG/03443	CAN, IDRC, JPN, NLD, UNICEF	UNICEF	0.429	3.7
11	SHP	Micronutrients	O	AFG/03444	CAN, IDRC, JPN, NLD, UNICEF	UNICEF	1.978	7.0
12	SHP	Building Afghanistan's capacity to address AIDS, TB and malaria	P	N.A.	Global fund to fight AIDS, TB and Malaria		3,125,605US\$ for two years were approved	
13	SHP	Emergency Preparedness and Response	O	AFG/03835	WHO	WHO	0.306	

	<i>Sub program*1</i>	<i>Project Names</i>	<i>Status*2</i>	<i>Government DAD project No.</i>	<i>Main Donors</i>	<i>Implementing Partners</i>	<i>1382 Com. In M. US\$</i>	<i>1383 Req. In M.US\$</i>
14	STH	Hospital Rehabilitation	O	AFG/03470	CAN, GER, JPN, UNICEF	UNICEF	1.972	7.33
15	STH	Hospital Construction	O	AFG/03468	ITA, USAID	UNOPS	11.531	21.9
16	STH	Equipment provision	O	AFG/03471	AUS, AUT, GER, JPN, USA	UNFPA, UNICEF	2.730	5.63
17	HRD	Pre-Service training	O	AFG/03476	BEL, JPN, USAID	UNICEF	9.667	12.40
18	HRD	Refresh/In- service training	O	AFG/03478	AUS, BEL, CAN, GER, JPN, UNICEF, USAID	UNICEF	5.340	3.0
19	HRD	Abroad training	O	AFG/03486	EC, UK- DFID, WB		0.509	2.60
20	HRD	Midwife training	P		USAID			
21	ARCB	Priority Reform and Restructuring	P	N.A.				

*1: BPHS: Basic Package of Health Services, SHP: Special Health Program, STH: Secondary Tertiary Hospital care, HRD: Human Resource Development, ARCB: Administrative Reform and Capacity Building

*2: O: On going, P: Planned

Annex 5 Technical Assistance Needs

Background and progress to date

After more than two decades of war, isolation, drain of human capital, and a resulting minimal resource base, technical and managerial weaknesses pose a serious constraint to Afghanistan's attempts to achieve its health goals. Therefore, in addition to funding for service delivery, complementary support is needed for the improvement of technical and managerial capacity.

The Afghanistan Interim Health Strategy (February 2003) defines capacity building as the development of organizational, managerial, and technical abilities, attitudes, relationships, and values that enable individual staff; groups such as departments, teams, and committees; and the Ministry as a whole to become more effective and efficient.

Towards this end, the Transitional Islamic State of Afghanistan with the support of its development partners has made progress in such areas as developing an Interim National Health Policy, conducting a National Health Resources Assessment, restructuring the MoH, developing the Basic Package of Health Services, creating technical task forces, convening a Consultative Group for Health and Nutrition, and writing Terms of Reference for Provincial Health Coordination Committees (PCC's).

This has been achieved through a variety of activities, including in-country seminars and workshops; overseas conferences, meetings, and training courses; on-the-job mentoring, coaching, and advising; and, material and financial support. A major input has been provided through international and Afghan expatriate advisors, short- and long-term, supported by the multilateral and bilateral donors. While much has been achieved, the remaining needs are significant, especially at the provincial levels, and in analyzing and harmonizing the different models of funding and support which have been introduced.

In addition to technical assistance to the MoH, Afghan NGOs, which will assume an increasing role in the delivery of health services in the future, have also benefited from similar types of technical assistance.

Summary of current technical assistance needs and challenges

Goals of institutional development

The stated MoH goals for institutional development are to ensure clarity of roles and responsibilities at different levels; develop strategic focus through priority setting and monitoring and evaluation; develop a management development program; and, develop appropriate management systems to ensure effective and efficient support services. These goals are supported by and consistent with the fifth sub-program objective of administrative reform and capacity building.

New roles and responsibilities/capacities and skills

1. MoH

In addition to having to overcome the reduction in institutional capacity and human resources resulting from years of conflict, the MoH's new roles and responsibilities require new capacities and skills. Specific management and leadership capacities which have been identified by the MoH and its partners include health planning, public health, financial management, leadership, human resources, governance, monitoring and evaluation, HMIS, donor coordination, community-based health care, and others. Most of these were not prominent in the clinically, especially hospital-based, oriented system of the past, especially when the MoH was virtually the sole provider of health services, rather than an overseer.

In addition, achieving an effective decentralized (or de-concentrated) health system will require many of these new management capacities at provincial levels, which were historically required to focus solely on delivering services.

Summary of Main MoH Technical Assistance Needs by Location

	Central	Provincial	Facility
Health Planning and Organization	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Public Health	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Financial Management	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Leadership	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Human Resources	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Governance	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Monitoring and Evaluation	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
HMIS	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Donor coordination,	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	
Community-Based Health Care	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>
Hospital Management			<input checked="" type="checkbox"/>
Logistics and Procurement	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>

2. NGOs

Over the last two decades, NGOs have become the main service providers, although increasingly under the overall guidance of the MoH. While a number of Afghan NGOs, due to their greater access to training and other human resource development activities enabled by their greater access to resources, have relatively greater capacity, technical assistance needs for others are significant.

At present, it is not clear that there is sufficient overall NGO capacity to deliver the BPHS in all areas of the country. Many areas remain underserved, and it is not clear what will happen when the few major Afghan NGOs begin implementation of their large performance-based grants and performance-based partnership agreements. These are likely to place larger demands on existing NGOs than has previously been the case, and concerns have already been raised about whether there is "too much money chasing too little capacity." Therefore, especially if the long-term desired trend is the replacement of international with Afghan NGOs, new NGOs will have to come into existence and current new NGOs will have to increase their capacity drastically.

In addition, NGOs which have been largely accustomed to working relatively on their own in a conflict or post-conflict setting with no or weak institutions, will have to become more able to follow policies, procedures, and protocols set up by the MoH. Improving the quality of

services and increasing the rate of cost recovery are other important areas in which NGOs can and must take a leadership role. Much of the above will require investment in the form of technical assistance.

Strategies for implementation

Types of technical assistance

Technical assistance will be provided through a variety of means, including the following:

- On-site support from International advisors (including Afghan expatriate)
- In-country training, workshops, and meetings
- Overseas conferences, meetings, and study tours

Principles of technical assistance

Technical assistance will adhere to the following principles, which have been articulated by the MoH in its “Policy Statement on Technical Assistance for the MoH Through Advisors.” Assistance should:

- Be systematic and integrated, not vertical
- Be appropriate to MoH priorities and needs
- Contribute to MoH overall strategy
- Be timely
- Be monitored and periodically evaluated
- Involve counterparts with clear roles
- Take into consideration the availability of necessary complementary resources

In addition, technical assistance will attempt to be innovative.

Coordination and management of technical assistance

The MoH will resume responsibility for coordination of technical assistance. In particular, technical assistance will be overseen by the Executive Board, which will regularly evaluate the contribution of advisors, with on-going guidance by the CGHN. As technical assistance moves from the immediate post-conflict phase to longer-term development, donors and technical agencies will increasingly harmonize their inputs.

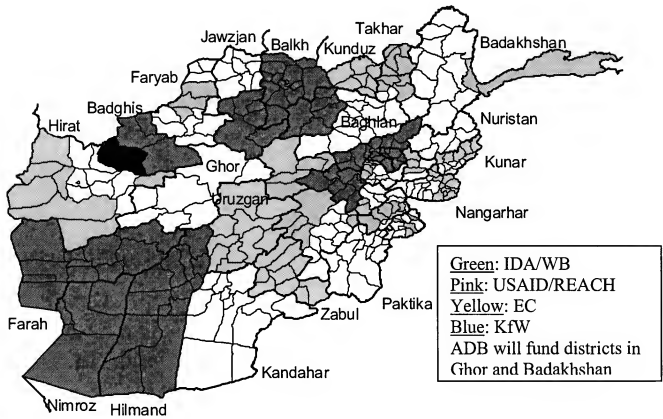
Constraints

Effective provision of technical assistance faces a number of constraints, including:

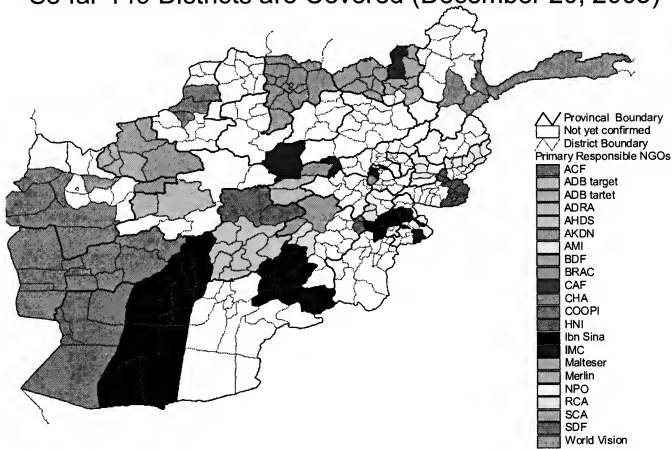
- Limited financial resources, including complementary ones needed to support MoH counterparts.
- The need to get agreement and/or approval from other concerned ministries on certain policy matters (e.g., civil service reform, budgeting and financial management).
- Security, especially in areas outside of Kabul.
- The need to coordinate and/or harmonize the different major donors’ models of service delivery and support, as well as their policy and political agendas.

Annex 6 Maps

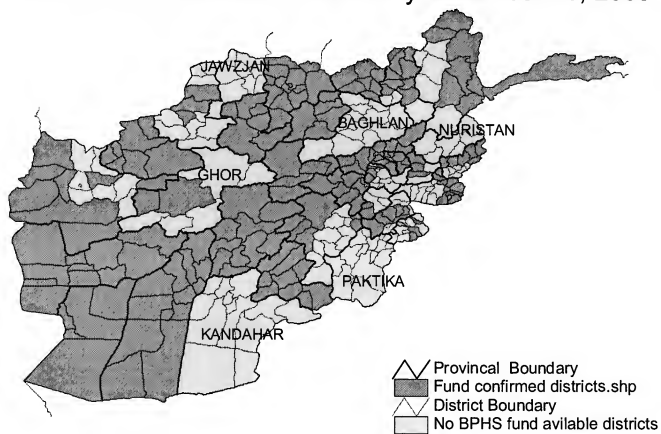
Map1: BPHS funding status by donor as of December 01, 2003.



Primary Responsible NGOs by Districts
 So far 149 Districts are Covered (December 20, 2003)



No BPHS fund avilable districts by December 20, 2003



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